NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

ANNUAL WORK REPORT 2008-09

(inclusive of the North East Regional Resource Center Work Report)

NHSRC

National Health Systems Resource Centre

Technical Support Institution with National Rural Health Mission
Ministry of Health & Family Welfare Government of India

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MISSION

Technical support and capacity building for strengthening public health systems.

QUALITY POLICY

NHSRC is committed to lead as professionally managed technical support organization to strengthen public health systems and facilitate creative and innovative solutions to address the challenges that this task faces.

In the above process, we shall build extensive partnerships and network with all those organizations and individuals who share the common values of health
to achieve its goals.

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Technical Support Institution with National Rural Health Mission
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September, 2009

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सत्यमेव जयते

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निर्माण भवन, नई दिल्ली - 110108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

Daated 16th September, 2009

MESSAGE

National Health System Resource Centre (NHSRC) has been set up under the National Rural Health Mission to function as a Centre of Excellence for facilitating implementation of NRHM. Registered on 8th December, 2006 as an autonomous registered society, it is mandated to channelize technical assistance and provide capacity building support to the States for strengthening of Public Health systems.

The corresponding institution at the state level for provision of technical support is The State Health Systems Resource Centre which NHSRC is facilitating to create. The NHSRC thus plays the dual role as the arrangement responding to immediate challenges and opportunities arising out of NRHM. At the same time it is involved in building up the institutions and Human Resource capacities at State Level which are required for architectural correction of the health systems in the long run.

The NHSRC is organized around eight health systems themes: Planning, Informatics, Human Resource, Quality Improvement, Financing, Community Processes, Health Administration and Legal Framework. The work done in all these areas is in turn linked to disease specific or programme specific areas.

The Annual Report 2008 — 09 captures the tremendous amount of work done by NHSRC in collaboration with various public health organizations, and with state governments and with various divisions of the Ministry of Health & Family Welfare. Its rapid growth in first two years into a leading and accomplished national organization with an excellent team of public health experts at its helm is a source of great pride to the Ministry and to me personally.

I congratulate NHSRC for publication of Annual Work Report 2008-09 and wish it all the best, in the years to come.

(NARESH DAYAL)

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

National Rural Health Mission

सत्यमेव जयते
Dr. R. K. SRIVASTAVA
M.S. (Ortho) D.N.B. (PMR)
Director General

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MESSAGE

The National Health Systems Resource Centre is a major step forward in the task of strengthening public health systems. As central funding for state health systems development increases, this requires to be accompanied by capacity building for decentralized health planning and management. NHSRC has put together in a short time a multi-disciplinary public health team that is able to contribute to these goals. A number of medical professionals with extensive field experience are working together with experts in areas as diverse as financing and informatics to act as a policy and strategy think tank for the ministry. In a short time, the NHSRC has been able to contribute significantly to strengthening planning processes, health management information systems, quality management in public hospitals, community participation in health programmes and many other areas.

However, the challenges are many and NHSRC needs to work closely with the Directorates of Health and Health Societies in the States to address these challenges. I greet this team on the occasion of the release of this first annual Work Report and wish them all the best.

(DR. R. K. SRIVASTAVA)

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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सत्यमेव जयते

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MESSAGE

The National Rural Health Mission envisages undertaking 'architectural correction' of public health systems to improve the access to quality health care services for the rural poor, especially women and children. NRHM works with the conviction that "health care for all" is not an impossible task to be achieved with in a firm time frame.

NHSRC supports the NRHM and the Ministry of Health & Family Welfare as a repository of knowledge and expertise, providing as well as channelizing technical expertise and skills, strengthening institutional capacity building, steering policy research and advocacy.

NHSRC functions under the guidance of a Governing Board headed by the Secretary, Ministry of Health & Family Welfare, Government of India, and an Executive Committee headed by the Additional Secretary & Mission Director, National Rural Health Mission.

The Annual Work Report of 2008-09 of NHSRC presents an overview of work carried out by various Divisions of NHSRC in Health planning, in development of Health Management Information Systems, in Quality Improvement, in Financing of Health Care, Legal Frameworks, Human Resources for health and in strengthening Community Processes in health care. The NHSRC also contributes to induction of technical skills and the creation of SHSRCs in the States. Emerging areas of work include Governance, Health Communication, Assets Management, Technology Assessment and Intellectual Property Right issues. The Work Report of RRC-NE, a branch of NHSRC is a part of this document.

I am sure that States and Union Territories would avail of the services offered by NHSRC to better the health care delivery systems of the State. I would like to place on record my warm appreciation of the Executive Director, NHSRC along with his team, for their contribution to strengthening NRHM. It has been an excellent beginning but there is much more that needs to be done and NHSRC must rise to this challenge.

16/9/09
(P.K. Pradhan)

Acknowledgments

The NHSRC would like to place on record our deep appreciation of the leadership provided by its Chairperson, Shri Naresh Dayal, Secretary, Government of India, Ministry of Health and Family Welfare. His encouragement and guidance was always there for us. There were many major constraints to the starting up of such an institution that only his wise and considered interventions could overcome. We also thank Dr R K Srivastava, Director General Of Health Services, who has provided constant guidance and encouragement to us. His reflective comments and probing queries have time and again helped us gain clarity on many key concerns and helped us to increase professional rigor in our work

We also gratefully acknowledge the leadership and support we receive from Shri P K Pradhan, Additional Secretary, Government of India, Ministry of Health and Family Welfare and Mission Director, NRHM. We are indeed fortunate to have such an able administrator, in the executive chair. Under his leadership, we look forward in the coming years, to being able to contribute even more actively and productively, in an even wider number of areas, to our mission of providing technical assistance and building capacities in the states.

We also place on record our warm appreciation of the guidance and leadership provided to NHSRC by Shri G.C. Chaturvedi who was Mission Director, NRHM from September 2007 to May 2009. If today within a government framework, the NHSRC has been able to emerge with considerable functional autonomy and clarity about the directions of its own development, the credit is largely due to his quiet and clear guidance, his inspiring role as mentor and his wisdom as an administrator. He helped us, a number of professionals from different disciplines and backgrounds, to understand government systems. He also helped government systems to understand and to tap the full creative potential of this multi-disciplinary professional team in the most effective and rewarding manner possible.

A special acknowledgment is needed for the immense pioneering role played by Shri Amarjeet Sinha, Joint Secretary, one of the key architects of the NHSRC. He has contributed most to shaping NHSRC as an independent body, fully supported by the government of India out of its own funds, which not only provides technical support and capacity building to the states, but also acts as an effective coordination of all technical assistance in this sector. Shri Sinha recognized that a programme like NRHM which is all about crafting credible public health systems would need at its helm specially designed support institutions. Much of the drafting of its carefully crafted rules and constitution, its initial registration and the first tasks given to NHSRC, were all due to his vision. He continues to actively guide the work of NHSRC.

Our special thanks to USAID for providing us with temporary rented accommodation, for almost a full year before we could set up our new office in the NIHFW premises. We also thank all development partners for their active interaction with us, and for permitting and encouraging their technical teams to work with us jointly on many key

technical issues. Our thanks also to NIHFW, who have so kindly rented out space in their premises for us to establish our central office, and who are our partners on many tasks we take up.

Most of the public health experts on our governing board have also contributed to mentoring our team on many technical and governance areas and we thank them for their support and encouragement.

Finally our thanks to over 70 partner institutions who have been working with us. We learn from them and we share with them. We grow along with them. Not unless we are able to create a fellowship amongst hundreds of such partners who bring different strengths to the table, but act in synergy to achieve the same objectives would the nation be able to achieve the vision of an universal, equitable, affordable and quality healthcare, which is accountable and responsive to the needs of the people.

T. Sundararaman
Executive Director, NHSRC

Contents

An Introduction

We present before you, the annual work report of the National Health Systems Resource Center (NHSRC); approved in its Fourth Governing Board Meeting held on August 5th, 2009. You will also find a brief note on the evolution of the NHSRC, its mandate as expressed in official documents, and its organization. Further, before each section, there is a small note explaining the NRHM context and conceptual framework within which the work of each division is planned. Though this report relates mainly to the period from April 2008 to March 2009, since this is the first year that such a report is being published, we have added some significant beginnings made even earlier.

We hope that this publication places the work report of the NHSRC in the public domain, and also builds an understanding of the possibilities for similar institutions at the state level. To facilitate this latter purpose we have annexed the official guidelines circulated for establishing State Health Systems Resource Centers.

Most of the work reported in the following pages has been done in strategic partnership with many agencies. Some of the work has been done as assistance to the divisions in the ministry- with these divisions also playing equal roles. NHSRC acknowledges with gratitude this massive cooperation that has made it possible to generate these modest outputs and looks forward to strengthening these partnerships. Since this is a work report of NHSRC, the report focuses on work done by NHSRC in each of these thematic areas. It does not cover other work done in each of these areas by the different divisions of the government or our partners.

Much of the work reported in this publication was in response to requests for technical assistance or capacity building from the states or from the various divisions of the departments of health and family welfare at the center. For reasons of brevity, we have not placed on record our response to many requests for technical assistance from states that required only an immediate or short duration response. Nor have we documented all the workshops and committees attended and contributed to. The work report is organized under nine themes. Most of the work in each theme is handled by one of the seven divisions into which the organization is structured. However in practice, most work involves contributions from more than one division, and sometimes there is work in one thematic area, which another division has undertaken.

The dissemination of this work report is part of the continuing effort to bring greater clarity to the agenda of strengthening public health systems and the contribution we can make to it, to strengthen existing partnerships and to forge new partnerships. We look forward to an active feedback from all our well wishers and from all those who work for strengthening public health systems to achieve these objectives.

PUBLIC HEALTH PLANNING

The NRHM throws a special challenge with regard to planning since it is designed for multi-pronged interventions and a paradigm shift in governance. Under NRHM, every district is supported to make its own district health plan, and the aggregation of these plans is the basis of the state health plans. District plans in turn are to be informed by village health plans and block health plans.

NHSRC is mandated to contribute to the task of decentralised, convergent and participatory planning for health systems strengthening at the state and district levels. While this requires building capacities within states in the planning teams, especially at district levels, several questions still need to be answered about the 'how' of such a shift in health planning; for instance the following:

- *How can plans be linked to available financial envelopes and resources and how can financing of plans be made more responsive to local needs and possibilities.*
- *What components should be planned for at what level of organization - village / block / district / state?*
- *Whose participation is necessary at what level and for what dimensions?*
- *How is convergent planning to happen in concrete terms?*
- *What structures and mechanisms will ensure that plans made in this mode are operationalised on the ground?*
- *How can plans be made more responsive to local needs and possibilities.*

We attempt to answer these questions as we work with the States. It is well recognized that while general rules of thumb can be provided as advisories to the states, operationalisation of these depends on the state context-the socio-political and administrative ethos as well as the history of health services development. States requesting technical support have to be responded to, and often such needs have to be pro-actively identified and provided. NHSRC has addressed these issues through a team incorporating public health persons versed with the theory and practice of public health planning and policy. We have taken the State Programme Implementation Plans and District Health Action Plans as the starting, and end points, of an incremental process of strengthening health planning in the states.

The following activity groups therefore characterize NHSRC contributions to the NRHM planning process:

1. *State Programme Implementation plan and District Health Action Plan appraisal for each state, as well as an analysis for cross-cutting themes across the states.*
2. *Capacity building and technical support to states for context-specific, participatory and convergent district planning and management, using information from local management information systems, and cross-state learnings.*
3. *Support for operationalising the plans-by identifying needs for technical assistance, then providing or coordinating provision of the TA or recommending ways in which the state could obtain it.*
4. *Monitoring and assessment of extent and quality of implementation to feed into planning and mid-course corrections.*
5. *Identifying information/knowledge gaps and information through (i) mapping studies, and (ii) action research, which we design and undertake in collaboration with partners.*
6. *From these interactions with the states, we are able to provide feedback for policy, as well as for technical reviews of schemes and programmes.*

Evaluations and Studies:

Common Review Mission (CRM)

This is one of the most important and central accountability mechanisms of the National Rural Health Mission.

This was a joint effort of many sections- the ministry, public health experts, civil society, development partners and NHSRC. Over 84 experts from different sections participated.

NHSRC undertook logistics of CRM, participated in design and in final compilation and preparation of drafts and in presentation of the report.

This report was presented in a national dissemination workshop chaired by the Hon'ble Minister of Health and Family Welfare where there were participants from the state and from every concerned section. The national and state reports are available on the website and also as a publication with a CD enclosed.

Mid-term review and Joint Review Mission (JRM) of RCH-II

Two consultants participated in third JRM Mission to Gujarat and to Orissa. One NHSRC Consultant also participated in each of the state teams that were sent out in the 6th JRM – to Jharkhand, Bihar, Uttar Pradesh and Chhattisgarh. However NHSRC had only a limited contribution to the final report- submitting its comments on some issues, mainly related to its own functioning.

Mainstreaming AYUSH study

Partner Institution
School of Oriental Medicine, Global Open University of Nagaland.

This is a study of the state of AYUSH services in the public health system, the influence of NRHM on the delivery of these services, the meanings of mainstreaming AYUSH at the point of intervention and the outcomes of such mainstreaming.

The study had two parts. The first is a study of the secondary material available on this issue, mainly the study of the State Programme Implementation Plans and reports. An Interim report that covers this part of the study has been finalized and published. It is also available on the website.

The second part of the study is a detailed primary data collection of the AYUSH public system and its interface with modern systems – from 14 states. The report is expected by year end.

Study of public health education institutions

The aim of this study was to gather a data base of all courses being conducted as related to public health, public health administration and management, and hospital administration and management and other interdisciplinary courses which prepare human resources for different public health functions with special focus on Decentralized Health Planning and Management.

The task involved identifying the institutions, the courses they offer, their stated objectives, an overview of their syllabus, the faculty they have, its qualifications and its accomplishments, their student intake and the placements they are able to attract. The study team is also visiting each of these institutions where the courses are on offer, to make first-hand observations and to verify the information. The study also documents courses related to public health on offer in medical colleges.

Study Partner

- Institute of Health Systems, Hyderabad
- School of Public Health, PGI, Chandigarh

5 partners (including 3 consultants, Dr. Dhruv Mankad, Dr. Krishna Soman and Dr. Shiv Chandra Mathur) and 5 part time consultants have been participating in this study. The study is not complete, but it is throwing up considerable new information. Thus in the southern four states alone more than 224 such courses have been documented. At the all India level as of now 559 institutions teaching 770 courses have been identified.

The study would recommend on ways of interaction with these rapidly emerging courses and ways to build up quality of faculty and discuss ways to increase the relevance of the course content and programme design to meet our national public health needs.

Capacity Building for Decentralized Health Planning and Management:

Partner Institutions

- Public Health Resource Network (PHRN) New Delhi
- Indira Gandhi National Open University (IGNOU) New Delhi
- Department of Community Medicine, All India Institute of Medical Sciences (AIIMS), New Delhi
- Indian Institute of Health Management and Research (IIHMR), New Delhi
- Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh

Capacity Building in District Planning and District Health Management.

This programme is conceptualized and implemented in partnership with the Public Health Resource Network. Another partnership with Indira Gandhi National Open University, provides for course participants to obtain an university post graduate diploma if they opt for it.

The Programme was aimed at building capacities of the district programme management staff. Both the regular medical programme officers and the newly appointed contractual managers are trained together in a 18 month programme which has 18 days of contact sessions. These 18 days are achieved in three rounds of 6 days each. The outcomes are improved quality of district plans and better implementation of plans. Key to the programme is the task of providing mentoring support and on-the-job training in between contact sessions, for completing a number of project assignments which has clear outcomes relevant to the district programme, but which also builds essential skills like, writing the plan, conducting situational analysis, implementing key components etc.

There is an option for those who want to get formally certified, to register with IGNOU and with the same programme qualify for a PGDDHM (PG Diploma in district health management) which would cost them Rs 10,000.

Partner Institutions

- Indian Institute of Management (IIM), Ahmedabad
- University of Western Cape, South Africa.
- AMOD Project, University of Colombia

NHSRC has been contributing to developing material, to providing resource persons for the course, and in financing the training programmes.

The programme outcomes are being measured by: number of trainees who participated, who were certified, the number of district plans made by the trainees, and the changes brought about in the district based on these plans.

Details of resource persons trained in each state under "Capacity Building for District Health Planning and Management Programme":

State	Batch	Round -1	Round -2	Trainee Profile:
Jharkhand	1	42	35	Programme officers and MOs from Dts.
	2	37		Programme officers and MOs from Dts.
Haryana	1	37		MOs, Dy. Civil Surgeons & DPMs from 10 districts
	2	40		MOs, Dy. Civil Surgeons & DPMs from 11 dts.
Bihar	1	36		Dy. Civil Surgeons, and MOs & DPMs from 10 districts
	2	50		Dy. Civil Surgeons, and MOs & DPMs from 10 districts
	3	85		Dy. Civil Surgeons, and MOs & DPMs from 18 districts
Chhattisgarh	1	47	21	State Programme Officers, DPMs, Mos
	2 -4	144		Programme officers and MOs and DPMs from Dts.
	5-8	98		BPMs, MOs, Account persons
Uttarakhand	1	39		State Prog.Officers, SPM,DPMs, CHMO, some DPMU
Orissa	1	35		DPMs, MOs
NE- ToT	1	54	58	MDs, State level Programme Officers from all NE states
Assam	3	148	139	District Programme Officers, DPMs, MOs, Accounts
Arunachal Pradesh	1	37	21	District Programme Officers, DPMs, MOs, Accounts
Manipur	1	44	50	District Programme Officers, DPMs, MOs, Accounts
Meghalaya	1	30	26	District Programme Officers, DPMs, MOs, Accounts
Mizoram	1	40	36	District Programme Officers, DPMs, MOs, Accounts
Nagaland	1	44	65	District Programme Officers, DPMs, MOs, Accounts
Sikkim	1	22	26	District Programme Officers, DPMs, MOs, Accounts
Tripura	1	30	26	District Programme Officers, DPMs, MOs, Accounts
Total:		**1114**	**503**	District Programme Officers, DPMs, MOs, Accounts

Capacity Building for District Level Epidemiology:

Build adequate in-service skills in epidemiology

There are 646 posts of epidemiology created under Integrated Disease Surveillance Programme (IDSP). Of these after advertisement we could find only 495 eligible candidates- even with very relaxed entry norms. Of which only 155 had an MBBS degree. And there were only 55 who had an MD degree or an MPH or any degree where epidemiology had been a paper. Only two institutions offer courses in epidemiology. Many of the doctors who were posted away from state headquarters did not join, even though salary scales had been relaxed to a starting salary of Rs 40,000 for a doctor. The system would have to depend on in-service epidemiologist training.

The IDSP programme and NHSRC with partnership of NIHFW, PHFI, Departments of Community Medicine of AIIMS and PGI, NIE, AMCHSS, AIIPHH and NCDC have therefore devised a training programme designed as an 18 month distance education programme with an initial 14 days of contact classes and then two further 6 day rounds. The course material is derived from the London School of Hygiene and Tropical Medicine course and the existing field training curriculum of the IDSP. The material is also available as an interactive self learning mode CD. The academic council of Sree Chitra Thirunal Centre for Medical Science and Technology Trivandram (SCTCMST) is certifying this course as PG Diploma in Epidemiology. Another major feature is an 'on the job mentoring with one mentor for every three trainees.

To train and then mentor the trainees, over 79 faculties drawn from 53 medical colleges and schools of public health, have been trained at National Centre for Disease Control (NCDC). The

Partner Institutions

- Shree Chitra Thirunal Institute of Medical Sciences Thiruvananthapuram
- National Centre for Disease Control, New Delhi
- Public Health Foundation of India New Delhi
- Department of Community Medicine (AIIMS), New Delhi
- School of Public Health, PGI Chandigarh
- National Institute of Epidemiology, Chennai
- All India Institute of Hygiene & Public Health, Kolkata
- National Institute of Health and Family Welfare (NIHFW), New Delhi
- London School of Hygiene & Tropical Medicine

training of the epidemiologists has also begun.

Expected outcomes are a more effective IDSP programme, an annual epidemiological profile for every district and epidemiological inputs into the district plan, more relevant and dynamic teaching of epidemiology in public health courses and initiation of epidemiology courses in more universities.

Capacity Building for Secondary Hospital Clinical Skills – the family medicine programmes:

Partner Institutions

- Christian Medical College (CMC), Vellore
- Dr. MGR Medical University, Chennai
- Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha
- Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh

Build adequate in-service clinical skills under the family medicine programmes

CMC Vellore has devised a family medicine course which is basically preparing an MBBS doctor to have an opportunity for skill based problem oriented continuing education on clinical skills. The level of skills developed would be enough to function as a multi-skilled doctor providing a number of clinical skills adequate to manage referrals from primary health centers. It is a two year programme with a provision for certification currently a Diploma in Family Medicine.

This course structure of this programme has been approved and clinical training centers have been located in the EAG states- combinations of not for profit hospitals and district hospitals. 120 candidates are now under the process of selection and the course is expected to start by September.

MGR medical university would also be ready to certify a more upgraded course with more surgical skills. At present the surgical skills set provided are limited. But the direction of development is to provide a second year of residential training – where skills of emergency obstetrics, conventional sterilizations, emergency anesthesia, some minimum trauma care etc could be taught and certified.

All these are purely in-service skill up-gradation courses meant to provide the secondary skills sets required for our district hospitals and CHCs (block PHCs). Expected outcomes are a more effective comprehensive secondary health care and public health centers.

(This work is being led by the Public Health Administration Team.)

Technical Assistance for Decentralized Health Planning:

Appraisal of State PIPs

Provided support to NRHM divisions for appraisal of state PIPs. Each PIP was reviewed by a team of at least three consultants and a set of comments provided to the ministry for their reference.

The State PIPs are also used as a source of information for analysis of what are the experiences and plans across states on select themes like the ASHA programme, child health etc.

The Public Health Planing team provided active support to many states in the making of district plans and for developing state level plan appraisal mechanisms. In particular we were required to play a major role in Bihar, Chhattisgarh, Uttarakhand, and Haryana.

Documentation of Planning Process and Outcomes

There is also an ongoing effort to document and understand the process of planning in the states. This goes along with a collection of the outcomes- the district and state plans – that were produced by this process. A critical reading of the district plans is undertaken and an overview appraisal and guide to the district plans is made available. The available district and state plans along with the final plan sanctions and the district overview appraisal are being made available on a CD for administrators, researchers and public health consultants. At any time one version is available that continues to get updated. The states for which this process is complete are: Himachal Pradesh, Jammu & Kashmir, Punjab, Gujarat, West Bengal, Madhya Pradesh, Orissa, Uttarakhand, Andhra Pradesh, Karnataka & Rajasthan.

Post-sanction Planning Support & its Implications :

One of the major constraints in district planning was that after there was a sanction of the state NRHM plan at Delhi, there was no follow up efforts to make a similar sanction to the districts and to also revise the district plans based on the final funds allocated to it. Without these steps the district plan as made and submitted becomes of marginal value- but if these are done, the plan could be a guide for action. The Public Health Planning team is following up on this and providing support to states where needed. States where this process has been completed are few. Some states have requested support in preparing District Health Action Plan (DHAP) based allocations to districts and this is being followed up.

The team also intends to follow up on this exercise to suggest ways in which the initial District Health Action Plan (DHAP) and State plan preparation effort can be undertaken so that the post-sanction effort required is minimal. In states such as Uttarakhand, where the DHAPs were prepared with a common framework, and were then aggregated to prepare the State Plan, the post-sanction allocations to the districts proved to be more simplified.

Technical advisory notes

The planning team also provides technical assessments and appraisals and comment on a number of queries from the divisions, states, Planning Commission and other bodies. Though a prompt response has to be sent, often some of these questions are taken up for a more substantial internal discussion, review of literature and evolution of a NHSRC understanding on these issues: A few examples of these are given below:

Standardizing Nomenclature of Health Facilities.

Revision of JSY guidelines.

Nutrition Interventions

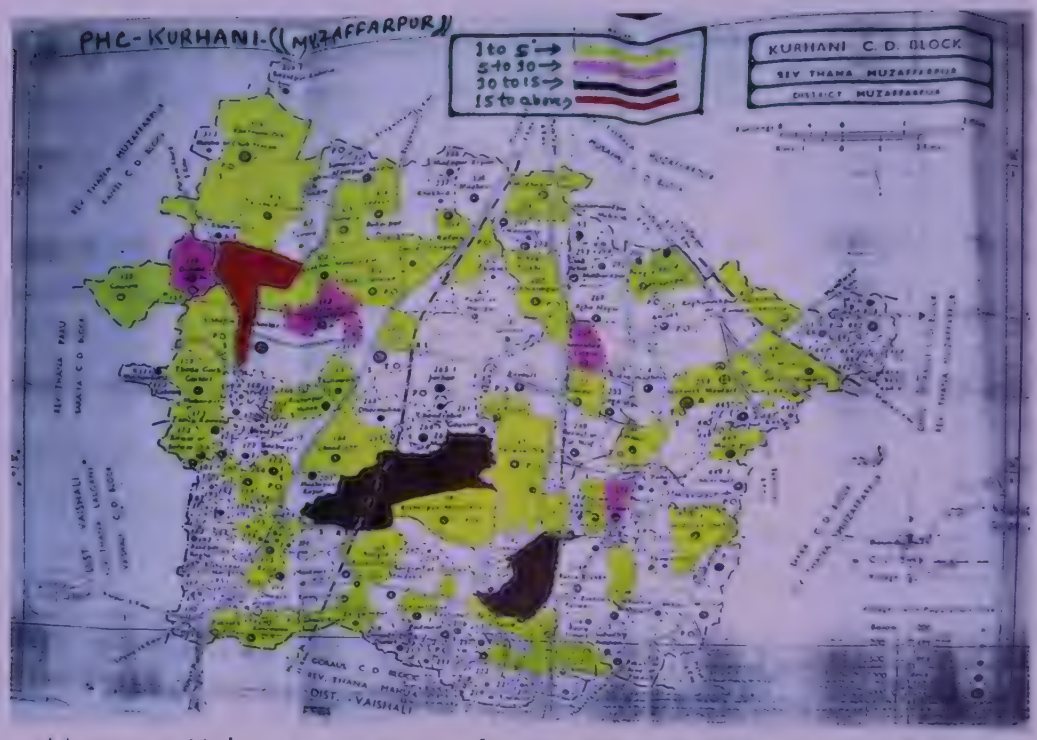
Urban Health Planning

Revision of School Health Program

Assessment of Operational Research proposals submitted to NIPI

Assessment of Technical Support Institutions and their capacity in various States, linked to recommendatory notes for Setting up of State Health Systems Resource Centre.

National Faculty Development Programme for Epidemiology



Mapping Kala-azar in Muzzafarpur, Bihar for District Health Plan

State TOT for ASHA training on Module-V in Ranchi, Jharkhand

HEALTH MANAGEMENT INFORMATION SYSTEMS

Under NRHM the challenge has been to build an HMIS that is supportive of decentralised planning and monitoring, empowering the facilities and the blocks and districts. Such an HMIS must be geared to provide information that is useful for action to improve health programme outcomes at every level of the system. One of the greatest challenges of the NRHM, is to integrate and share information flows across the existing HMIS of various vertical programmes and state health systems.

Efforts at building an HMIS are not new in India, having a history that dates back to at least 1988. Almost all states with health systems development programmes worked on developing HMIS in the nineties. However success was limited and most systems did not sustain beyond their project period. Learning from such experience in India and world-wide, the effort has been to establish some fundamental principles of design for HMIS that could be the basis of a renewed national effort tailored to the NRHM's paradigm shift:

The main principles of design that are required to meet these objectives are :

a. *Collecting only those data elements that contribute to indicators and can be reliably provided by service providers.*

b. *Defining the hierarchy of indicators - such that at the national level only a few indicators relevant to policy are computed, while at the district and sub-district levels a much larger number of indicators can be added on as needed by local programme managers.*

c. *Promoting the use of free and open source software, to enable large scale use of applications, a much higher degree of local customisation, the possibility of continuous evolution of the applications over a much longer period of time, easier integration with many other diverse systems that are running and to avoid vendor lock in to proprietary software.*

The main implementation model that emerged was the use of a national web-portal to satisfy national reporting requirements and to place verified data on the public domain, integrated with DHIS-2 free and open source software, for use in sub-district, district and state levels for analysis and use of information – and an electronic bridge connecting the two. The DHIS-2 is installed only in those states which request this application for level analysis & use of information.

This implementation model requires negligible expenditure on software, but it requires a massive investment in capacity building and sustained hand-holding so that the easily acquired skills of entering data are seen only as the starting point to achieve the much more challenging objective of every facility and block and district having the capacity to analyse and use the information for action that leads to significant programme improvements.

NHSRC Contributions :

The First Phase - January 2008 to September 2008

First Phase Objectives : Situation Analysis an Rationalisation of Data Elements.

Under NRHM, there had already been concerted efforts to strengthen the monitoring system. The most important of these was to put in place contractual human resources in the district and state level. The second was to introduce a new set of reporting formats. NHSRC work began with a situation analysis of the data on flow from the states. This was able to point out specific problems on data flow and data management at all levels. Most important, it pointed out that over 1400 data elements were being asked for, but much less was actually received and even of this only a small part was used. Based on this a major effort at rationalisation of data elements asked for was started which used five guiding principles:

a. To ask for only those data elements which related to the services personally delivered by the service provider- and therefore was reliably known by her. Record of births and deaths was an exception to this.

b. To ask for only those data elements that could be used to make an indicator. If the denominator could not be defined or collected, not to ask for such an indicator.

c. To avoid duplication of data elements- not ask a service provider to report the same data element in more than one place and not by more than one service provider.

d. To avoid or at least reduce to a minimum data on disaggregations of a data element- especially by caste, but also by gender except for important exceptions. These are better collected through survey.

e. To shift to quarterly or annual forms, what was not needed on a monthly basis.

These simple steps reduced the load of data collection to just about 70 data elements for the sub-center and only about 300 data elements for the whole district – on a monthly basis. They made monthly reporting with much greater validity possible. Care was taken to provide every indicator that programme divisions needed which could be got without violating these principles

Two more principles were elucidated- one was line listing of births and deaths. This was accepted (with conditions) for deaths. Another principle proposed by NHSRC which was that of the hierarchy of indicators. There would be few national indicators, a larger set of state indicators and maximum number of indicators at district and block level. Blocks and districts would transmit most information up as indicators- not as data elements except for a very few core data elements. Thus at the block or district level there would be about 300 indicators made and used but at national level only about 15 indicators would be made- the rest would only be available as indicators. This was however not opted for.

The process of rationalisation of data elements was completed by September 2008.

In parallel a national web-portal for reporting data became operational in October 2008.

The Second Phase - October 2008 to April 2009

Second Phase Objectives : To get systems functional in all states in 6 months, completely upload all data into web-portal: Deadline - March 31st, 2009. 90% Achieved by April 31, 2009.

The work of this phase could be categorized in three parts :

1. **Capacity Building to upload data into Web-portal:** Over 628 districts of the "640" districts have now got the capacity to upload data into national web-portal. Data of 12 months are uploaded from all states. Quarterly forms and annual forms also uploaded from most states. M&E division did the first round of training at national center. Then over 1800 training-person days clocked in all the states by NHSRC to train district HMIS personnel to create the district aggregated record and upload the data. Training was for building skills to upload data on web-portal and to use the DHIS-2 for local analysis of data. Training was also to create these district masters from aggregating all the facility data. Troubleshooting and on-the-job support was also needed till this entire deadline was reached. Training also included introduction of new formats and some principles of data collection.

2. **Legacy data challenge:** Problems regarding the entry of legacy data was largely solved using DHIS-2 installed on NHSRC or state servers and functioning addition to web-portal. This was used in 25 states to map legacy data from old formats/e-records to new formats and then upload them. Often this was done centrally. Particularly prone to error because of systems being in a developing state. In many states data was available only as hard copy and NHSRC had to undertake data entry to create the e-records and then map data into new formats and enter it.

4. **Ownership of data:** Building this was one of the main issues addressed. Data comes from different sources, under different chains of command; no set procedure exists for validating / owning the data- therefore huge delays occur in 'confirming' data. Some states have notified state nodal officer and a few have constituted a state HMIS team – but most have not yet done so. Multiple claimants to the data at state level and sometimes a contestation of the same is also seen. At district level district data entry manager gets his data approved by the CHMO. This issue of ownership remains a challenge.

Partner Institutions

- Health Information Systems Project (HISP), India

The Third Phase - May 2009 onwards

Third Phase Objectives: To improve data quality and promote the use of information: One of the main problem of this stage is the poor Quality of Data. This is mainly attributed to :

To improve data quality and promote the use of information: One of the main problem of this stage is the poor Quality of Data. This is mainly attributed to :

a. Lack of use of information for local planning and action: HMIS comes to be seen only as an accountability mechanism and is used only for reporting above. Data sent up is not seen, or if seen, is adjusted to meet expectations.

b. Poor standardization of terms and meanings.

c. Problems of duplication due to 'area based' reporting in addition to facility based reporting

d. Persistent use of old or inappropriate forms.

e. Lack of space in primary 'recording' registers or inability to collect that data.

It may be noted that contrary to popular belief, NHSRC experience and international experience in this area shows that poor data quality is seldom a function of deliberate provision of false data by service providers. This problem exists but has a marginal contribution.

To address these problems NHSRC contributions are as follows:

Strengthening Use of Information for Action : To strengthen use of data for local analysis, display of information, feedback forms and use, NHSRC has introduced a district level tool – the DHIS-2 applications: as of now it is functional in 17 states. This application also allows customization to include new indicators and integration with IDSP, diseases control programmes and functions such as HR Management and Hospital Management etc.

Data is entered at the following aggregations:

Sub-center level : Gujarat, Kerala, and Chandigarh (block level computerization in first two and civil dispensary level in third).

PHC level: Punjab, Karnataka, Jammu division (11 districts), (block level computerization), Manipur, Mizoram.

Block level: MP, Himachal (all at block level except 2 districts), Orissa(block managers entering at district), Bihar (block managers entering at district level- moving to block level entry), Uttarakhand

District level- moving to block level: Kashmir division and Maharashtra, Nagaland, West Bengal, Puducherry, Meghalaya

In the NE, application has also been made available for Tripura but because of NIC firewalls in the NIC network they use, makes it impossible for them to access the application. A similar situation exists in Meghalaya, but they try to address this problem by using cyber cafes etc for their data entry. In the past, a similar situation was experienced in Rajasthan. It is thus important to approach NIC on this.

In all these states we have introduced state, district and block level analysis and use of information, with in-built validation protocols for each level. NHSRC has also customized applications in each state to take in state needs for information – with addition of new indicators, data elements, and sometimes even modules which are relevant to that state. Such district and even block and facility level customization is possible- but these have till date been restricted to the addition of data elements.

The following states are currently not using DHIS: Rajasthan, Uttar Pradesh, Haryana, Jharkhand, Chhattisgarh, Assam, Andhra Pradesh, Arunachal, Tripura, and 4 UTs. Of these UP, Assam and Arunachal and Tripura needed DHIS-2 for legacy data.

In UP, it is being introduced through 4 regional training programmes, with piloting in 4 districts to try out block level entry.

In Rajasthan, in collaboration with BITS Pilani, a plan has been developed to adopt Jhunjhunu district for district and sub district level use of DHIS2 and integration with the web portal at the state level.

Tamil Nadu enters upto sub-center level, and computerization is at PHC level. It however uses multiple systems for district level use and is now replacing all these by a TCS developed new applications. DHIS- 2 is used as a bridge between the new system and the national web-portal. (the national web-portal currently does not allow software bridges with other systems- and one has to convert other system outputs into a coded excel sheet compatible with its excel sheets and upload it in that format). In addition to being the bridge with the web portal, DHIS2 in Tamil nadu is being used as the tool for carrying out the data analysis (indicator generation, data quality etc) and in providing feedback to the levels below.

Andhra Pradesh also has its own district systems but manually converts its outputs into district aggregates and manually enters it into web-portal.

Barring a few expectations like Tamilnadu, the NHSRC-HISP provided solution is the only tool currently available for local analysis and use of information.

Improving Quality : Capacity Building

Constant capacity building is needed for interpreting information. A deviation from the expected data should be seen as useful information and the purpose of the exercise, rather than suppressed by asking reporting units to conform to expectations. This requires capacity to analyse and interpret the data with a Public Health understanding.

To assist this process, fifteen HMIS fellows have been recruited from leading institutions and given a special training and deployed in all states except those in the southern and the north east region. Most are public health graduates or IT graduates being prepared for a career in health informatics. Their main task is to help states and districts analyze, display and use their data- and in the course of this, they learn to differentiate data collection and entry errors from useful deviations and this in turn means that problems of quality diminish greatly. The Fellows, though only about 2 months in the field, have played an important role in data quality analysis and in the finalization of the 2008-2009 data.

Capacity building in the form of training programmes for service providers on data collection and reporting and for mid-level managers on use of information is also ongoing and would need to be accelerated in this coming period.

Improving Quality : Use of Indicators

When data as absolute numbers is added up from across more than 30,000 reporting units with over 5000 points of aggregation - given the varied quality and time of reporting, the certainty that a significant percentage of centers will not report with quality or not report on time - and the uncertainty of not knowing precisely which centers are defaulting, all these would mean inherent limitations in quality and use of data, when aggregated across the nation. It is much more useful to collect most data at national and state level as indicators. NHSRC is therefore building understanding on importance of having a hierarchy of indicators, and the ability at every level – especially at district and block level - to cast and use indicators. [Note: Thus a block or district manager should derive about 300 indicators from as many data elements and transmit this up to state and national level as indications. At the national or state level we would use indicators to know how effectively different districts or blocks are performing. Only a small selection of data elements would travel to national level as data elements to measure a national indicator or a state level indicator. To give an example a data report at the state level on institutional delivery would give the percentage of institutional delivery achieved in each block and not the total number of deliveries. This way a few blocks with poor data quality would not jeopardise the use value of the data from majority of blocks across the state.]

Improving Quality: Introduction of GIS

GIS applications promote use of information; GIS integrated into DHIS-2 has now been introduced in four states: Kerala, Gujarat, Orissa, and Karnataka. This application extension is available for free (normally GIS software costs crores). The application is ready to be introduced wherever maps for that level are made available. Many states have seen the GIS module and have expressed a keen interest to adopt it for their state, but the difficulties in obtaining catchment boundary maps have impeded the process.

Improving Quality: Standardizing terms and collection methods and facility names.

A data dictionary and indicator manual has been developed which standardizes the way terms are interpreted and used and the way data is collected. (Eg till what number of weeks is it an abortion and when does it become a still birth? Does the ANM report a delivery from her area that has been conducted in CHC etc)

Guidelines for standardization of nomenclature of facilities have also been introduced with clarity on hierarchy of facilities.

(e.g. is a home delivery done near a PHC attributed to the facility or to a notional sub-cente, does a PHC at the block headquarters serving many CHC functions but not formally named so, count as PHC or as CHC, etc).

Various other implementation support material have been created, including guidelines for data aggregation, implementation framework, roles and responsibilities of technical team at state etc, and these are being distributed through the fellows. Formats have been translated in Hindi and Gujarati, and the use of them in respective states would also contribute to improving data quality.

Improving Quality : Primary Registers

Partner Institution
Japanese International Co-operation Agency (JICA-RCH Project)

Many data elements are not correctly available because there is no space in the recording registers to enter such data. Further the design of the register does not lend itself to easily computing totals. Some states have registers weak in tracking functions (e.g. of eligible couples, of pregnant women, of children below 2).

Primary register design must allow the service provider to record the services delivered as and when she gives it, it must allow her to track services given for some user categories and thereby it must allow each computation to reach ministry aggregates.

Drafts of primary registers have been developed in partnership with the JICA-RCH project and field tested. Model registers are now available for use by states.

New Technologies :

New Technologies-1 : A Mobile Based Data Transmission:

Partner Institutions
- Health Information Systems Project (HISP), India
- Department of Informatics, University of Oslo.

Technology has been developed by which the ANM can upload the data required from her onto a customized screen in her mobile and SMS it across to the most peripheral point of computerization (mostly PHC), with the added functionality of the same SMS being sent to the block, district and state levels. The SMS is directly imported into the DHIS 2 application, where it is then integrated with other facility data for the creation of the monthly reports. In the pilot study carried out in 5 states, it was found that the ANM takes on an average 5 minutes or less to upload the monthly data. The travel time of ANM is fully reduced, the time spent on aggregation of sub-center data reduces and quality of data improves. Further, the application can serve as an excellent training tool for the ANM on data elements. Piloting of this has been completed in five blocks of five states – Himachal, Rajasthan, Kerala, Nagaland, and Gujarat. Technology is now ready for expansion state-wide in all states which are ready for the same. Application is free- only costs of the mobile (about Rs 4000 per mobile) and training need to be borne by the state. A number of other states have also seen the application and expressed their desire to try out the same.

New Technologies-2 : Hospital Information System. This is being developed as an open source free application using OpenMRS which is globally used and WHO/HMN endorsed. This includes the patient registration module using biometrics and is in advance stage of development. The first prototype has been successfully demonstrated in Doon hospital on 21st July, pilot implementation is being planned.

New Technologies-3 : Patient tracking in Leprosy - Integration of Leprosy with the routine health system has been done, and is being demonstrated to Maharashtra state, from where the request originated. This is a name based system to track patients through their treatment. Other states have also expressed an interest to use such an application.

New Technologies-4 : User tracking for pregnant women and children under two - Development of immunization and pregnancy tracking is underway, and is expected to be ready for demonstration in September. Pilot is in Gujarat. This is also a name based system. Linked to the mobile it would be able to send a very high quality of feedback in addition to tracking.

New Technologies-5: Integration of Malaria program at sub centre level and district wise reporting through web portal has been carried out and is ready for testing. A similar integration is under development for IDSP.

New Technologies-6: Integration of state specific HR management system into district HMIS system. This is being worked on for Bihar. Many states have expressed their interest as major part of state health budget is in human resources.

New Technologies-7: Development of each of the above has led to a demand / suggestions for an applications that integrates all the above: HMIS, IDSP, DCPs, finance, HR, infrastructure, patient based database etc. NHSRC participated in an international workshop, organized in Goa by IT developers and health informatics specialists, on how to address this complex challenge.

Institutional Development :

The challenge is to develop state level capacities for server management, for further software development where needed and for being able to customize reports according to local needs. Since it is open source software, systems should be able to make further customisations and build on their applications. Also there is a need to build a data depository at each level.One thrust is to get states to recruit a set of IT and public health skills needed for this purpose- at least a team of three. After one year these three should be fully trained and NHSRC appointed HMIS fellows should become redundant. These newly recruited and trained staff could be placed in their respective SHSRCs and SPMUs.

Another thrust is to develop capacities for health informatics in some public health institutions in the form of faculty, who can also be called upon by the states to provide technical support in the form of consultancies. These institutions could also be geared to conduct public health informatics courses or offer an optional on this in their MPH programmes. Such alliances are being developed with BITS Pilani. The PH Informatics programme of Jamia Hamdard University, New Delhi, the AMCHSS, Trivandrum and with AIIMS, dept of community medicine. Many more such partnerships are planned.

Partner Institutions

- Tata Institute of Social Sciences (TISS), Mumbai
- Birla Institute of Technology and Sciences (BITS), Pilani
- Dept. of Public Health Informatics, Jamia Hamdard University, New Delhi
- Department of Community Medicine (AIIMS), New Delhi
- Achuta Menon Centre for Health Sciences Studies, (AMCHSS),Trivendrum

National Health Observatory

Team is working on it in partnership. Most fields populated–but relatively slow progress-information collected but not uploaded fully. Currently use limited to NHSRC work details, data base of institutions and consultants, recruitments etc. Conscious decision to focus on other HMIS work. Registered users 200; approximately 50 visit at the site per day.

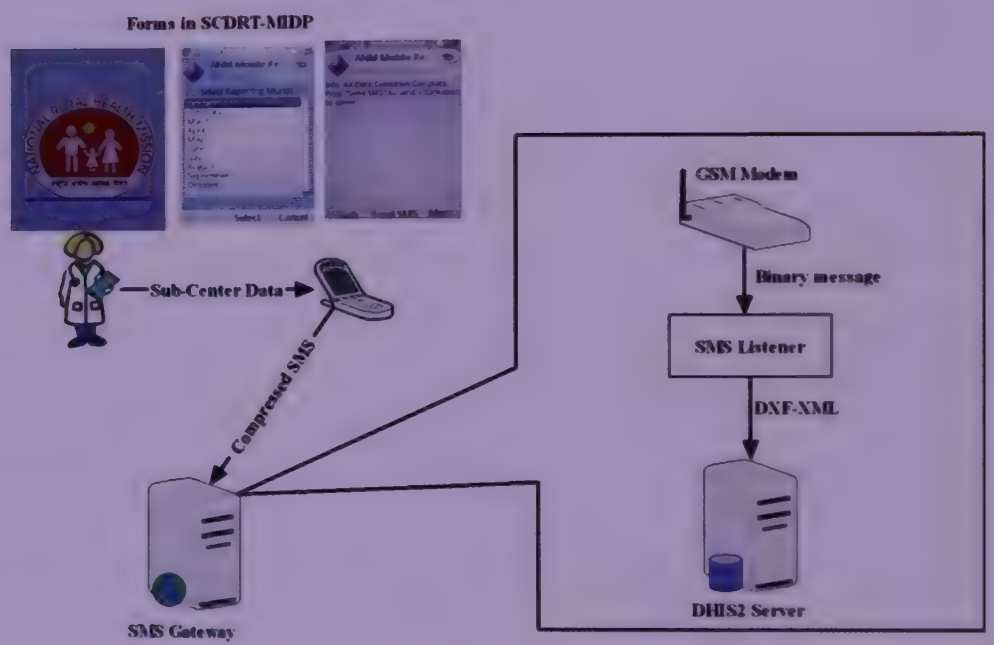
Note : As of today, the website has become more user friendly and has much information useful for health planning. The website address is www.nhsrcindia.org.

Partner Institutions

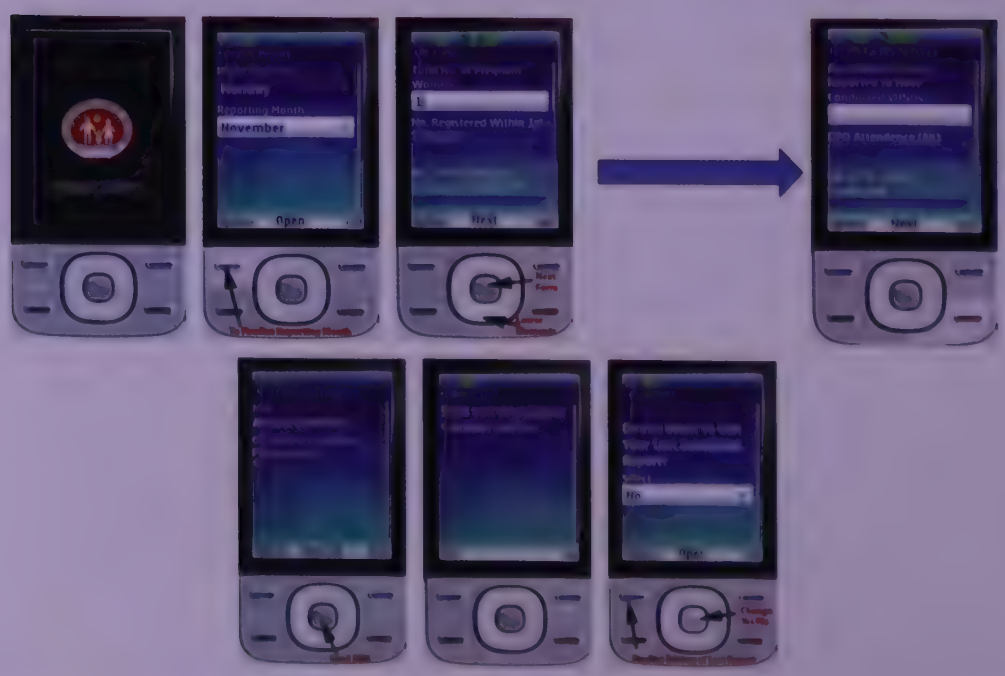
- World Health Organisation (WHO), India
- Vistaar
- MCH - Star

A Block level Health Facility in Tribal District of Chhattisgarh

Mobile HMIS Data Transmission



User Friendly Mobile Data Screens



QUALITY IMPROVEMENT IN PUBLIC HEALTH SYSTEMS

In the context of a health service, the aim of quality care would be that it is effective, that it is safe, that it is timely, that it is efficient, and that it is community centered and equitable. A Quality Management System (QMS) refers to the specific organization of a set of processes that leads to the guarantee of quality services. Since quality is not static, the QMS must not only be sustained, it must allow for continual improvement cycles making QMS a way of life. Or to put it differently, QMS must become the defining part of the work culture of that facility.

Public Health Systems need a QMS to benefit users by ensuring quality of service provision, for ensuring efficient utilization of resources and to provide for transparency and accountability in the functioning of the health system. A good QMS in place also generates a sense of pride and achievement for health care providers. This is particularly important in a context where Public health systems manage a huge patient load but do not get appreciated for the efforts and where public perception is that public sector cannot match the private sector in quality.

The Indian Public Health Standards lays down the minimum specifications for infrastructure, equipment, human resources, drugs and supplies. It also specifies the minimum service guarantees that need to be reached. The NRHM is committed to providing the resources needed for states to achieve the IPHS in all their facilities. The QMS acts as a complement to the NRHM thrust on IPHS by ensuring that the investments made in reaching the minimum standards of infrastructure, human resources and supplies translate into service guarantees. For between the two are factors like motivation, the organisation of work, the quality of leadership, the integrity of processes, the capacity to manage contracts and many other management skills. These are the factors that a QMS addresses. For any given level of inputs that is available, the quality of outputs in terms of quantity and quality of services provided can and must be maximised.

The NHSRC's direction is to develop an approach that can be scaled up to the entire state- so that all facilities have a quality management system in place. In the private sector, one driving force for quality accreditation is to attract more patients and profitability in a competitive market. This does not apply to the public sector. The challenge of the public sector is that, we would be able to make QMS certification the norm for all public health services, only if there is a deep social commitment to ensuring that the poor who form the bulk of the clientele of the public sector hospital are as entitled to a minimum quality of services as anyone else, and as true professionals, all health care professionals take pride in the fact that the services they provide never compromise on quality.

Building QMS for District Hospitals

Pilots - One District Hospital in each of 8 'EAG' states:

The objective was to develop a Quality Management Systems (QMS) Approach applicable to public hospitals, which could ensure quality of service provision for whatever services were available given the limitations of HR availability and infrastructure. Such an approach would parallel and even, if unavoidable, precede further developments of HR and infrastructure needed to meet IPHS norms. Six district hospitals are now ISO certified- Korba (CG); Allahabad (UP), Dehradun (Uttaranchal), Puri (Orissa); Deogarh (Jharkhand), Karauli (Rajasthan). Two more - Katni (Madhya Pradesh)) and Arah (Bihar) would achieve this by September, 2009.

Note : The choice of the ISO route as compared to other options was because (a) it was feasible (b) it was affordable (c) it had national and international recognition (d) its standards were transparent (e) it had no conflict of interest between management consultancy and external audit team.

The programme had three distinct phases.

In the first phase a team of consultants conducted an "As-Is" study which was a situational analysis and a baseline measurement of the "quality gap", in 24 key processes that NHSRC has specified, in addition to the six mandatory ones.

In the second phase, in discussion with each of the stakeholders and in consultation with domain experts solutions were found for "traversing" the gaps and meeting the process requirements for a streamlined and optimal functioning of identified administrative and clinical processes.

Then in the third phase, as part of traversing the gaps and meeting process requirements, documents were introduced into the system which tracked each process, with clarity on who should maintain the document and who is accountable for the integrity of that process. At this point training was the major input. In parallel an effort started to close identified infrastructure, human resource and supplies gaps- where IPHS was the guiding document, but with a achievable baseline target of improvement set for the period leading to the audit and with a road map for further improvements subsequently. With a certain degree of improvement, internal audits were organized and when the system had shown signs of consistency, the third party external audit was called in. All the district hospitals taken up except for Arah (Bihar), successfully passed the external audit.

Third party external audit at Arah district hospital resulted in three major infrastructure related non conformities and hence its certification has been denied till situation improves. The civil surgeon was transferred three days before final audit and new civil surgeon is unable to have repairs effected for want of funds. Since, considerable progress was seen, a second date was provided for a second audit. Still, progress has been difficult. Katni (MP) is in final stage of system development.

Handholding contracts are in place for all 6 hospitals who have achieved ISO, and will last three years to take them forward in this journey.

Technical Assistance Agencies

- Hosmac India
- Medica Synergie
- ICRA
- Perceptions

Expansion of quality certification of hospitals to NE states

Two sensitization presentations to state officers done, One district hospital in each state, identified by respective states. Agencies procured and contracts issued. All states would have one ISO certified hospital by March end (see NE-RRC work report also).

Expansion of Quality Improvement – NHSRC-ISO approach:

Agency supported QMS:

Sensitization meetings were held in Bihar, Jharkhand, Maharashtra, Kerala, Tamilnadu and Andhra Pradesh for senior officers. States have verbally indicated the need for expansion to more district hospitals and some PHCs/CHCs. Requests for more district hospitals are as follows: Bihar- 48, Jharkhand- 10, MP- 5, Chhattisgarh- 3, Uttaranchal- 3, Haryana- 6, Orissa- 3, Andhra Pradesh- 2, Kerala- 40 (mainly CHCs), Tamilnadu- 50 (PHCs). Formal request is underway for Tamilnadu and Chhattisgarh. In North-East process is underway in 8 pilot district hospitals, one in each state.

Partner Institutions

- Indian Institute of Health Management and Research (IIHMR), Jaipur
- IIHMR, New Delhi

Self Implementation of QMS:

NHSRC has been developing an approach to scaling up the development of QMS in public facilities so that it could become part of state policy. Currently NHSRC is developing manuals on quality improvement. The first manual identifies over 100 quality gaps and shows how in different contexts these could be addressed in different ways. This is being accompanied by another manual on quality management systems in the public hospital context. These manuals would be used as a training module for hospital administrators – who would be then followed up and supported till their hospitals are ready for external audit under the ISO process.

List of processes on which quality concerns are addressed in this approach would include the mandatory general 6 procedures required for ISO 9001 certification, plus 12 administrative processes and 12 clinical processes. In addition the programme includes an equity sensitization component, with three important sub-components: exemption from user fees for the poor, women friendliness of the hospital, and sensitization to prevent social exclusion.

The approach would also be fully integrated with RCH and quality assurance system which is basically a check-list based monitoring approach, and the IPHS as a specification on minimum inputs and service guarantees. This would thus place every facility on a road map to achieving certifiable quality. A district or regional approach is proposed- to this self implementation model of QMS would be tried out. Certification would be a combination of external (ISO) and internal (the state body would ensure that all essential parameters are addressed or are on the road map.)

It is proposed to begin testing this approach with Orissa, but more states are open to join in. In Orissa the team of five stakeholders - the medical superintendent and his deputy, the contractual hospital administrator, the chief matron and a local government RKS member were trained together to initiate the process in each district hospital. States need to put in place a quality improvement expert at the state level and be ready to invest in more manpower for the same in the district and facility level.

This approach is not entirely external TA agency free- but the external TA agency plays a different role of support to the internal management. Main purpose of this approach is to reduce costs and increase coverage of QMS, while addressing the issues of scaling up.

Social Marketing of Sterilization Services-developing systems for:

To meet the huge supply side shortfall to respond to growing unmet needs in sterilization, a process of accrediting and reimbursing private providers had to be put in place, such that it was consistent with key policy requirements of a PPP.

Note : On subsequent discussions it was decided that further initiative on this programme could be left to the states.

ISO certification of NHSRC:

All processes completed. Third party external Audit was conducted on 24th June 2009, and NHSRC has been certified to ISO 9001:2008. NHSRC found this process of ISO certification useful to streamline its own administrative and programmatic functioning, and for its organizational development.

Signage project:

Good quality of signages is a must for patient convenience. However procuring an agency that could do this effectively and managing such a contract had proven surprisingly difficult for a number of states. A standard terms of reference has been issued and panel constituted by calling for expression of interests. A Model Request for proposal is prepared.

ISO Certification of CRHSP hospital, AIIMS:

AIIMS has a peripheral hospital at Ballabhgarh, which, at their request has been taken up for developing a QMS. Induction visit has been conducted and "As-Is" Study starting soon.

Partner Institutions

Department of Community Medicine, AIIMS New Delhi

Biometric Registration component in Hospital Management Information systems:

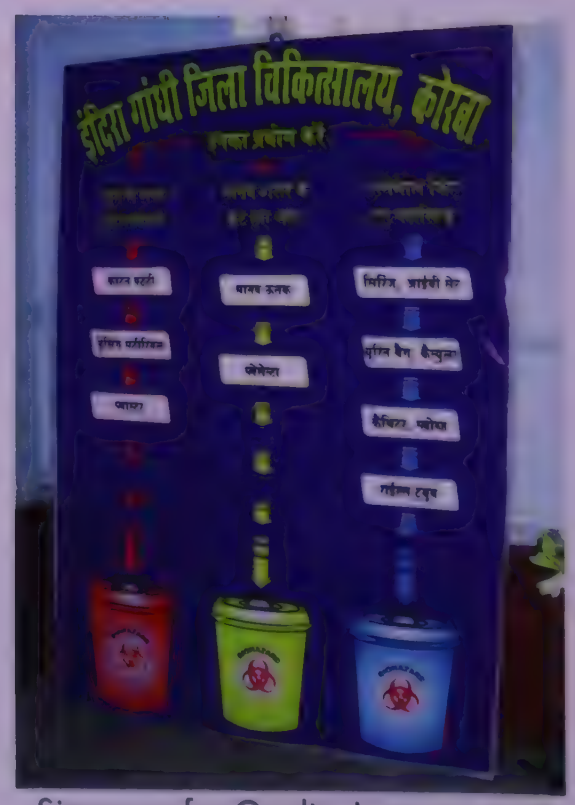
In collaboration with HMIS division, it is proposed to introduce biometric registration of patients as part of a Hospital MIS, so that record of patients is easy to retrieve, and entitlements especially BPL status is easy to verify and deliver. On site discussions / sensitization has been done at Dehradun district hospital which is the pilot programme for this approach. Eventually Hospital MIS using biometrics would become a part of quality certification of the hospital.

NHSRC's Approach:
Mandatory Quality Improvements.
(To supplement IPHS)

Clinical Procedures:	Hospital Administration Procedures:
1. Outdoor Patient (OPD) Management	1. Patient Registration, Admission & Discharge Management
2. In-Patient (IPD) Nursing Care Management – including labor room management	2. Medicine Stores & Inventory Management
3. Medical Emergency Management	3. General Stores & Inventory Management
4. Family Planning Management	4. Procurement & Outsourcing Management
5. OT Management	5. Hospital Transportation Management
6. Hospital Diagnostics Management	6. Hospital Security, Safety & Disaster Management
7. Blood Bank Management	7. Hospital Finance & Accounting Management
8. Hospital Infection Control & Sterilization Management	8. Hospital Infrastructure Maintenance Management
9. Clinical Care Data Management	9. Hospital housekeeping & General Upkeep Management
10. Hospital Referral Management	10. Human Resource Development & Training Management
11. Hospital Waste Management	11. Dietary Management
	12. Laundry Management

Equity and Accountability Areas (not under ISO certification- sensitization inputs)

1. Women friendly features- also baby friendly hospital & ASHA friendly hospitals:
2. Economic Equity sensitization- identification and exemptions for the poor, special support where needed- eg place to cook food, access to welfare entitlements / NREGA provisions for family members of the sick etc.
3. Quality of functioning of Rogi Kalyan Samitis- including quality of public participation.
4. Preventing Social Exclusion: Sensitization to needs of specially marginalized sections.



Signages for Quality Improvement

FINANCING OF HEALTH CARE

One of the major goals of the NRHM is to increase the public expenditure in health from the current 0.9% of the GDP to 2 to 3% of the GDP. The design proposes that to achieve this, both states and the center should increase their expenditure on health, but the ratio of state to centre in health expenditure should shift from the current 80:20 to a more sustainable 60:40 ratio.

One need that arises from this is to be able to track public health expenditure in the center and in the states to be sure that both health expenditures are rising. Equally important is to ensure that the increased expenditure is balanced between primary, secondary and tertiary and that it is equitous between states and within states. We would have to examine the proportional allocation to areas like human resources or on drugs and supplies to argue the case for such expenditure to reach up to national and international norms. Health departments also need to develop systems for procurement of goods and services and for infrastructure development that are efficient, effective and timely.

One problem that the public health sector has faced is its poor absorption of funds. The causes for this need to be understood and addressed. Flexible financing whereby funds flow more to areas of higher utilisation of services without losing sight of equity and quality considerations is one challenge that needs to be addressed. Efficiency in allocation and use of resources is dependent on building in more such flexibility.

In the nineties a number of alternative financing options emerged. This includes user fees for cost recovery, health insurance schemes, social franchisee programmes and a wide variety of public private partnerships. Many of these did not live up to their initial promise, and something like user fees which was so central to health sector reform in the nineties is clearly out of fashion now. Another generation of public private partnerships and health insurance programmes have started up in this decade- and their experience needs to be studied. The NRHM also seeks to engage with the private sector in a number of partnerships, through which it seeks to increase investment for public health and access to health care. However it takes skills to design and to manage contracts.

The NHSRC focus in the area of health care financing therefore addresses four main areas:

a. *Budget and expenditure tracking based on a few clear indicators,*
b. *Understanding fund flows and costs at the district level and working out ways for more efficient and timely use of funds.*
c. *Analytic documentation and capacity building to better understand and design partnerships.*
d. *Assets management: Review and support.*

Public Sector Health Budget & Expenditure Tracking:

There is a need to keep track of where center and states are with respect to increase in public health expenditure. There is also a need for an annual analysis of public health expenditure on some key parameters.Baseline information on state health expenditures available from secondary sources are put together and this is updated from time to time. This "Health Budget and Expenditure Report version 3.0" is available. However the information available in this is not adequate to guide decision making.

National consultation workshops deliberated on current methods in use, sources of data, their strengths and limitations and what can be drawn from them for this purpose. A set of 10 essential "budget tracking indicators" and another 9 desirable indicators were short-listed in the workshop. The criteria of inclusion in this list was that these indicators were essential and, as a set, largely adequate for decision making. Also that it was feasible to collect and compute these indicators on an annual basis with limited effort and skills.

Seven organizations with strengths in health economics, formed a partnership to pilot this approach and collect data from 10 states and compute these indicators.

A post data collection workshop held on March 14th, 2009, reviewed the tools developed and worked to standardize definitions and methods.

This "Health Budget and Expenditure Tracking" Report is ready for 10 states. Tool kit for health budget and expenditure tracking is ready. This contains list of indicators, their definitions, the data needed to cast these indicators, the exact sources from which this data would be available and the cautions and constraints on calculating each of these. Using this tool kit a state level consultant on financing and an institution for each state could be oriented to cast these indicators on an annual basis. The center would be able to make meaningful cross-state comparisons and look at broad allocation and expenditure patterns in each state. A dissemination and capacity building workshop for the tool kit is planned in September. This should lead to such budget data becoming available for all states.

Partner Institutions

- Institute of Public Health Bangaluru
- Institute of Health Systems Hyderabad
- Centre for Multi Disciplinary Research (CMDR), Dharwad, Maharastra
- Institute for Socio-Economic Change (ISEC), Bangaluru
- ICICI Centre for Child Health and Nutrition (ICCHN), Pune
- World Bank India Technical Team
- GTZ India Technical Team

13th Finance Commission - Grants to States

At the request of the 13th finance commission to the ministry, NHSRC submitted its inputs to the ministry in the form of two papers:

A. What constitutes primary health care '

B. Principles on which to work out Equalization grants for health systems; and estimated grants to states in accordance with these principles.

Both these input papers were further developed and submitted by the ministry. These have been accepted by the Finance Commission and found very useful. The papers drew upon the budget indicators developed and the studies of NHSRC.

Further study, refinements and discussion on this is planned.

District Level Fund Flow & Expenditure :

Developed proposals for district level fund flow and expenditure tracking study. This work is planned in six states- Rajasthan, Himachal Pradesh, Karnataka, Bihar, Kerala, Tamilnadu.

Institutions have been identified to undertake these studies. This should lead to financial indicators of district expenditure, and inputs for streamlining financial management and to build district financial planning tools.

PPP assessments : EMRI

EMRI evaluation first phase completed and on website.

The evaluation was done by a four persons NHSRC team assisted by three senior national consultants- Barun Kanjilal, CK George and VR Mureleedharan and guided by two state mission directors on the committee. The study looked at only secondary data, but as there was a wealth of documentation available, even this was very informative. This was supplemented by detailed discussions with the EMRI team and other interviews at state and district level. The study provided a detailed picture of the design and operation of the programme and the challenges it is facing, and the choices before state and national policy makers with regard to the future of this programme. The study showed that while EMRI was undoubtedly an effective and valuable service, it had high costs, and at such costs it could be sustainable only if there is a substantial increase in overall public health expenditure. Amongst its many recommendations, two key recommendations were for having an contract management cell under the government which could monitor and independently validate the claims made, and for governance reforms in the EMRI system.

Going by the feedback, the evaluation has made a difference. A wide variety of stakeholders, ranging from the EMRI to state governments to GVR (its new management), have found the report useful and informative for making critical decisions.

Other PPP assessments

Assessment of 4 PPP- MOUs in Rajasthan- report presented to MD, Rajasthan.

Assessment of other Emergency Response Systems – Janini Express, MP, the Bihar ambulance PPP and the CAT ambulance service.

Assessment of PPPs in human resource development has also been undertaken.

The proposal is to focus on major potential and promising PPP models – including schemes like RSBY, HMRI etc in the future.

Technical Assistance Agencies

- Ernst & Young Pvt. Ltd.
- Grant Thronton India Pvt. Ltd.
- Medica Synergie

Procurement Audits & Infrastructure Audits :

Final Reports available for 5 states. Reports identified major gaps in the states. Gaps could be categorized into failure to observe rules, inadequacy of rules themselves, inadequate processes, or lack of capacities. Tamil Nadu was also audited as part of the process of treating TNMSC as the benchmark. Feedback was provided to the states.

Procurement admit could not start up in Uttar Pradesh.

Review Workshop was held on 30th March, 2009.

Follow up is planned to strengthen procurement systems, in these states.

Similar work for Infrastructure Audit has been initiated.

Urban Health Plan

Assisted the development of the plan by working out Financing Plans of National Urban Health Mission- for different policy options and strategy choices.

Response to states

This team has been consulted by states for many appraisals & procurement processes. e.g. procurement committee of Punjab for SHSRC, PPP appraisals for Rajasthan, Procurement committee of Haryana for ERS etc.

Short-list of Key Public Health Expenditure Indicators

Indicators	Numerator/Denominator
1. Change in health budget over previous year.(nominal)	(Current year's total health budget) – (Previous years total health budget)
	(Previous years total health budget)
2. Change in State's own contribution to State Health Budget over previous year	(State's contribution to health budget in current year)– (State's contribution to health budget in previous year)
	(State's contribution to health budget in previous year)
3. State Health Budget as proportion of Total State Budget	Total state health budget
	Total state budget (including CSS and EAP)
4. State Health Budget as percentage of State GDP	Total state health budget
	State GDP
5 State's per capita Govt. Health Expenditure	Total state health budget
	Estimated mid-year population
6 Per capita health expenditure by State's own resources	State's contribution to health budget in current year
	Estimated mid-year population
7 (a) State's share in total health budget	State's contribution to health budget in current year
	Total state health budget
7 (b) Center's share in total health budget	Central contribution to health budget in current year
	Total state health budget
7 (c) Share of foreign funding in total health budget	External (foreign) contribution to health budget in current year
	Total state health budget
8 (a) Proportion of total govt. health expenditure on Primary healthcare	Total public expenditure on primary care
	Total state health budget
8 (b) Proportion of total govt. health expenditure on Secondary healthcare	Total public expenditure on secondary care
	Total state health budget
	Total public expenditure on tertiary care
9. Capital health expenditure as percentage of total public health expenditure	Capital expenditure in health
	Total state health budget
10. State's own share in NRHM resource envelope (allocation)	State's contribution to NRHM
	Total NRHM funds

Other suggested desirable indicators:

1. Per capita expenditure on Medicines and Drugs/Supplies; proportion of total health budget; rate of growth in nominal terms
2. Expenditure on Maintenance as percentage of Total Revenue Expenditure
3. Conditional cash transfers (JSY, incentives for sterilization/NSV, etc.) as percentage of total health/total NRHM expenditure
4. Total HR Expenditure (treasury + contractual payments) as percentage of total health expenditure
5. Contractual payments to staff (under NRHM) as percentage of total HR Expenditure (treasury + contractual payments)
6. Procurement (Capital expenditure on METP + Revenue & Capital Expenditure on Medicines Drugs and Supplies) as percentage of Total govt. health expenditure at state level
7. Proportion of NRHM budget (sanctioned and expenditure) on Salaries/contractual payments, Medicines, Civil Works, Equipment procurement, ASHA and VHSC and community processes.
8. Ratio of NRHM budget & expenditure on salaries of administrative/programme management staff and the remuneration to contractual staff as health care providers: Expenditure by Untied funds (minus VHSC) as percentage of total NRHM expenditure; untied funds-expenditure as percentage of sanctions.
9. User fees as percentage of total RKS income (current year) (and percentage of patients being exempted from user fees if this is in place)

LEGAL FRAMEWORK OF HEALTH

The agenda of strengthening public health systems requires to be supported by measures to strengthen the legal framework of health care.

One important dimension of this is working towards building and strengthening a rights-based approach to health in the country. The right to health is to be viewed as being inclusive of right to underlying determinants of health, and to this right being actually realized by the people without any discrimination and gaps. One core strategy to achieving this is a national health act. To reach this stage, a draft National Health Bill is prepared and now in the process of discussion.

Another important dimension of the building a legal framework is an examination of all existing laws related to health, to see how far they are compliant with the spirit and intent of the national health bill- something which would become mandatory if the bill is passed, but which task can begin even now, as many health related laws are under review to make them more rights based and effective.

A third dimension of work in this theme is capacity building in the health sector leadership at every level to understand and fulfil their legal obligations.

States struggle with other legal issues that come in the way of strengthening public health systems. One instance is how over one third of a health secretary's time in some states could get unproductively absorbed in legal cases. Yet there is little systematic thought on how to reduce this load or on building capacities to manage it more efficiently. Another instance is the cobweb of laws and litigation holding down any efforts at better workforce management or human resources development. Providing responsive inputs to Union/ State Governments to help with legal issues, so as to build an effective public health workforce is another major area where technical assistance is needed.

Finally there are areas like regulation of the private sector in health care provision, in pharmaceutical oversight and regulation, and in issues like intellectual property rights, where governments need legal support.

Given current capacity, the NHSRC has begun its contribution in this thematic area, with the health rights bill and the examination of few laws in this framework. It would construct strategic partnerships and promote institutional capacity building in this essential but under-recognised area of work.

National Health Bill

Various versions of draft National Health Bill were prepared, presented and improved upon, till a draft version was approved for being placed in public domain. Draft discussed with states twice - at Puducherry National Workshop and at CCHFW meeting. Draft is available on NRHM website for public comment.

Prepared background papers including one on "framework law" to elaborate on the rationale of different aspects of the National Health Bill.

Legal obligations of district officer- PHRN manual

A training module for district officers on their legal obligations has been prepared and printed. This is Book 13 of the Public Health Resource Network's Training Module on District Health Planning and Management. A training of trainers for this module has been completed.

Responsive inputs on health related laws/issues

MTP Act: Submitted the draft MTP amendment Bill towards expansion of MTP services and methods of MTPs, and strengthening the rights framework. This has been utilised by the ministry as a valuable input; Also prepared the justifications for each amendment in the MTP Act on the basis of current international and national legal standards and advocacy demands; Presented the draft MTP Amendments before the sub-committee and the ministry; Also involved in the ongoing process of drafting the amendments for extension of gestational age for MTPs from 20 weeks to 24 weeks for foetal abnormalities; MoHFW has agreed that this process must be merged with the earlier process of broader amendment, to consolidate the draft amendment bill.

Also involved in finalizing of the service delivery guidelines for comprehensive abortion care

Submitted detailed analysis and feedback on draft Clinical Establishments Regulation Bill

Submitted detailed analysis of the proposed Bill on regulation of Assisted reproductive Technologies (ART Bill)

Research and documentation

Carried out research and collation of laws, international standards & judgments on health. This is updated on an ongoing basis.

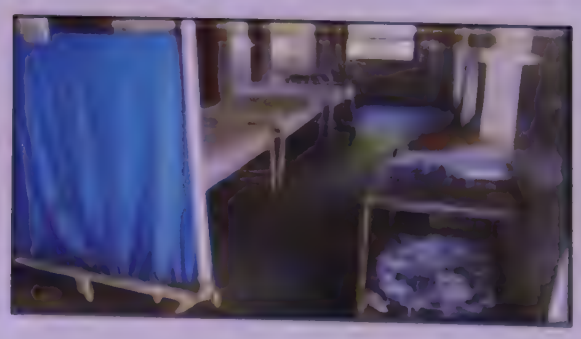
Improving Quality in Public Hospitals
NHSRC - ISO Certification Process

Disabled Friendly, Patient Friendly-Puri Hospital

Before	After

Bio-Medical Waste Management

Before	After



HUMAN RESOURCES FOR HEALTH

One major component of strengthening public health systems under NRHM, is the commitment to increase the skilled human resources deployed to the minimum levels needed for a functional system. In parallel with this, the health sector would need to address all the constraints that limit the performance of the workforce already deployed in this sector. These include the difficulty in attracting and retaining skilled professionals for work in rural and remote areas of the states, and related to this, the problem of absenteeism and poor motivational levels. It also includes the challenge of being able to keep the skills of such a large workforce upgraded and in lines with the growing needs of the health sector.

The adoption of the Indian Public Health Standards has sensitised the administration to the minimum human resource needs at all levels. This has been able to reverse the trend of the nineties which saw, and perhaps actively encouraged, a shrinking public health workforce. Over 75,000 employees have been added to the public health workforce in the last three years – and this is not counting the 700,000 ASHAs. However, despite this impressive achievement, in the human resource depleted states of the north and north east, given the lack of growth of professional education in the recent past, even the candidates necessary to meet these requirements are difficult to find.

The NHSRC has been contributing to this cause by sustained evidence based advocacy on the gaps between minimum human resource required as per national and international norms and what is currently available. It is also documenting and sharing interesting experiences from all states where problems related to the retention of workforce and improvements in performance have been addressed. It also contributes by assisting states to systematically study and then design state specific plans to address the human resource situation. On many occasions it is called upon to respond to specific questions regarding existing institutions or schemes.

One thrust area of the NHSRCs contribution to human resources in health is promoting and assessing creative and pragmatic solutions by which the necessary skills are created and retained in rural and remote areas. Another thrust area is on the development of in-service capacity building programmes in areas like public health management, in epidemiology, and even in the area of clinical skills upgradation for the primary and secondary level health care provider such that we move towards comprehensive medical care at these levels.

Nursing Studies

Studies completed for four states by Academy of Nursing Studies- Bihar, Orissa, Rajasthan and Chhattisgarh. Converted into action plan by state in multi-stakeholder meeting for Bihar and Orissa. Study ongoing for Uttarakhand- data collection completed. Other states to follow this process.

Partner Institutions

Academy of Nursing Studies & Women Empowerment Research Studies (ANSWERS), Hyderabad

Medical Officers and Specialists studies

On receipt of requests for the studies from six States, academic institutions were identified to conduct the studies. The Terms of Reference were distributed to all institutions that responded to an EOI and from these, institutions for conducting studies were identified. Study tools were finalized in consultation with these academic institutions. The collection of data has been completed in three States of Uttarakhand, Jharkhand and Rajasthan. The field teams were trained and work is under progress in Karnataka and Gujarat.

The aim of these studies is to come up with state specific recommendations for addressing key HR issues with regard to this category of the workforce, and to base these recommendations on evidence and adequate stakeholder dialogues.

Partner Institutions

- Achuta Menon Centre for Health Sciences Studies, Trivandrum
- Indian Institute of Development Management, Bhopal
- Institute of Health Management & Research (IIHMR), Jaipur
- Institute of Public Health, Bangalore
- Social Policy Research Institute, Jaipur
- Public Health Foundation of India (PHFI), New Delhi

Nursing Action plan facilitation

The faculty development programme for Uttarakhand has been taken and 40 candidates are identified for training in Andhra Pradesh and Pondicherry. The NHSRC technical support for strengthening of nursing HR is being provided for Bihar and Orissa as well.

Retention of workforce studies

Study design finalized in consultation with SHRC, Chhattisgarh and PHFI. Data collection is ongoing. This study documents the various strategies for attraction and retention of the workforce in different states. It also studies the effectiveness and workforce issues of non MBBS clinical service providers in the Chhattisgarh context and it also looks at background factors that have led to a number of doctors opting to stay and work in rural areas- which could be of relevance to evolving new strategies.

Partner Institutions

- SHRC Chhattisgarh
- Public Health Foundation of India (PHFI), New Delhi

Workshop conducted on HR issues and public health management in Puducherry – October 2009

Workshop held at Puducherry with participation of all states.

Draft report of Task force on strengthening public health management and workforce issues was prepared and submitted with background evidence notes on many topics. The papers are available on our website.

Supported by

- DFID India
- WHO India

Documentation related to HR

Incentives across the states have been documented and it is proposed to disseminate these to States.

HR data collection formats have been developed based on IPHS norms and HR data collected from 94 districts across 14 States for understanding the HRH gaps in different contexts

Development of Model Job Descriptions and Recruitment Rules

Job descriptions of essential categories of Human Resources collected from States (Kerala, Gujarat, Madhya Pradesh, Pondicherry, Rajasthan etc) and under compilation. Recruitment Rules of essential categories of Human Resources collected from few States and under compilation. These are being shared with the states along with appraisal comments so as to assist states in drafting/improving their own rules in this regard.

Sri Naresh Dayal, Secretary MOHFW at workshop on Human Resources for Health - Goa

COMMUNITY PROCESSES UNDER NRHM

One of the key components of the "architectural correction" envisaged under the NRHM is to strengthen community participation in all health programmes. Community processes are not to be confined to the community as beneficiaries. The community is seen as playing an active role in the design, implementation and monitoring of health programmes.

The major schemes through which community processes are strengthened are

a. *The ASHA programme*

b. *The Village Health and Sanitation Committee.*

c. *The Untied fund provided to the sub-center and the VHSC and the space provided for public participation in these decisions.*

d. *The Rogi Kalyan Samitis (or hospital development committees) as a vehicle for public participation in facility management and the provision of untied funds for this purpose.*

e. *The district health societies and the district health planning process.*

f. *The community Monitoring programme.*

g. *The involvement of NGOs in the mother NGO programme and in public- private partnerships of different sorts.*

All reports and evaluations show these schemes to be making a positive impact and many of these programmes are the public face of the NRHM. However most assessments also show that there are significant gaps in the implementation of each of these programmes in the states and some process of active support to address these gaps is essential. It is not easy for a technical-administrative apparatus to overnight reform itself, and let the community in- much less in roles where they could be overtly critical.

Also each of these programmes have a number of facets, and a common sense approach underestimates the technical inputs that are involved in design and implementation of these programmes. Many of those who have experience of community based work have limited experience of scaling up programmes to the entire state. Many state governments have limited experience of working in partnership with civil society agencies especially in roles where they are involved in the conceptualization and design of the programme on a continual basis. Yet, this is what communitisation needs.

The NHSRC's primary contribution is to assist states in developing support structures and capacities at every level to conceptualise, guide and monitor these processes. As the secretariat of the ASHA mentoring group, it enables the contribution of expertise from within civil society groups to the government for implementing this programme and it facilitates similar arrangements at the state level.

Secretariat to ASHA Mentoring Group (AMG)

Meetings of ASHA Mentoring Group are held regularly on a quarterly basis. Recommendations of AMG are followed-up at both national level as well as in the states. Some ASHA mentoring group members are playing an active support role by visiting the programme in states and giving their comments and recommendations. A Technical Resource Group (TRG) of AMG has also been formed and one meeting of this group has been held. In view of expansion of ASHA programme and problems in the states, this would be held more regularly. The minutes of the AMG meetings & TRG meetings are available on the NHSRC website.

National ASHA Mentoring Group

	Name of AMG Member	Organisational Affiliation
1	Dr. Abhay Bang	Society for Education, Action and Research in Community Health (SEARCH), Shodhgram, Gadchiroli, Maharashtra
2	Dr. Alok Mukhopadhyay	Voluntary Health Association of India (VHAI), New Delhi
3	Dr. H. Sudarshan	Karuna Trust, Banglore, Karnataka
4	Mrs. Indu Capoor	Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad, Gujarat
5	Dr. K. R. Antony	State Health Resource Centre, Raipur, Chhattisgarh
6	Dr. N. F. Mistry	Foundation for Research in Community Health (FRCH), Mumbai, Maharashtra
7	Ms. Neidonuo Angami	Oking Hospital, Kohima, Nagaland
8	Dr. Nupur Basu	Child In Need Institute (CINI), South 24 Pargana, West Bengal
9	Dr. Prakasamma	Academy of Nursing Studies, Hyderabad, Andhra Pradesh
10	Dr. Prashant K. Tripathy	Ekjut, Chkradharpur, West Singbhum, Jharkhand
11	Dr. Rajani Ved	Independent Public Health Professional, New Delhi
12	Dr. Sharad Iyenger	Action Research and Training for Health (ARTH), Udaipur, Rajasthan
13	Mrs. Shilpa Deshpande	ICICI Centre for Child Health and Nutrition, Pune, Maharashtra
14	Dr. Shyam Ashtekar	School of Health Sciences, Yashwant Rao Chavan Maharashtra Open University, Nashik, Maharashtra
15	Dr. Thelma Narayan	Society for Community Health Awareness, Research & Action (SOCHARA), Bangalore, Karnataka
16	Dr. Vandana Prasad	Public Health Resource Network (PHRN), New Delhi
17	Dr. Vijay Aruldas	Christian Medical Association of India (CMAI), New Delhi

Support to ASHA training

Partner Institutions
Centre for Health Education, Training and Nutrition Awareness
CHETNA, Ahmedabad

The objective was to achieve round V by December 2008, and to achieve at least 12 days of training per year after this, and also to improve quality of training. The achievement falls short of expectations. Long gaps between training rounds, and training is well behind schedule in many states.

Main problems faced have been due to lack of deployment of any support structure or recruitment of NGOs who can provide training support. In many states dedicated team is in place exclusively to organize this programme.

Training up to round 4 has been completed in all NE states, Orissa and Uttarakhand. These are the states which have done relatively better. Also about half the ASHAs in Madhya Pradesh have done round IV. Combined ten day training of 2, 3, 4 being done in Jharkhand, Rajasthan, Bihar, and UP. Completed in Jharkhand & Rajasthan, but in Bihar ten districts are in training at this level, rest to start even this. In U.P. 92% of this training completed.

State level training of trainers have been conducted by CHETNA, supported and facilitated by NHSRC & NE-RRC in Guwahati (for Assam), in Agartala (for 4 NE states), in Dehradun and in Bhubaneswar. District trainers have been trained in other three NE states. Training of ASHAs has begun in these states. Sole dependence on CHETNA as the only national training team, was one constraint. With development of national training team, made of trainers sponsored by NGOs, this constraint has been overcome. Training team has also skills needed to support state groups to develop further material and plan training programmes.

NHSRC with the help of Asha Mentoring Group needs to provide much stronger advocacy and support to states to keep ASHA programme on line. The most important reason for ASHA in many places not going beyond JSY and immunization facilitation is her low level of skills and support for undertaking any other task.

Building up ASHA support structures

At state level: Asha Resource Center or equivalent institution has been established in Uttarakhand, Jharkhand and Orissa. Process yet to start in rest of the states. NHSRC has appointed a state facilitator to provide state level support in all the 8 EAG states – but except in Orissa it has not been adequate to put change in place. However state facilitators have contributed significantly to even this level of achievement & in many states are the main state level managers of the programme.

At district level: District mobilisers are in place in Orissa and UP and almost there in Rajasthan and Madhya Pradesh. Rest of the states are yet to start. Sub-district facilitators are in place in Uttarakhand and Orissa only.

There is no instance of Community Health Worker programmes being ever able to deliver without adequate support structures in place. Addressing this is therefore a priority. NHSRC has had limited success in its efforts to explain this to states and to provide them with the confidence and techniques of putting such a large workforce in place and also supporting and sustaining it.

Community Programme Management Skills: Technical Support to states on other Community Processes

Many players in this area have poor recognition of how much experience and innovation and even study, it takes to manage these programmes. A common-sense based approach seldom suffices. These are very large programmes and managing them requires not only a dedicated team, but a combination of those who have worked with communities, who have experience of innovating with management processes, and who have a public health knowledge. Such a combination is rare and the only way, is to get individuals with some of these skills and train and support them for the rest. These community programmes e.g. ASHA, VHSCs therefore take off, but struggle to go beyond the initial steps. Though they show significant outcomes, they still function, well below their true potential. There is also a trend to quickly attribute weaknesses to policy/strategy constraints without fully exploring what can be achieved with-in given policy and choice of strategy.

Areas on which some states have sought and been provided with technical support are:

a) drug kit refilling logistics

b) incentive payment management,

c) social mobilization processes,

d) accreditation/certification issues.

e) choice of indicators and development of monitoring plan for both the ASHA programme and for the VHSCs

f) Building up grants-in-aid processes for selection, induction and management of NGOs to support these programmes.

g) Linking payments for support structure personnel to performance.

h) Developing multiple diverse types of model village health plans and even examples of innovative uses of village untied funds.

I) developing training programmes for VHSCs

On these and many more similar areas, almost all states require sustained NHSRC support, as leaderships change and there is no ASHA /Community Processes Resource Center in place to keep on learning and build an institutional memory on these issues. RRCs have not risen to or have not been enabled to fill this gap either.

NHSRC's team has been effective on monitoring support to the MOHFW, but needs to be geared up to provide both technical assistance to states and to build programme management capacity in these states – once the support structures are put in place. Even state level advocacy for promoting greater focus on community participation would be an important role.

A strategy for building partners who could be charged with the role of state facilitation is also being developed.

Partner Institutions

- SEARCH Gadchiroli
- PHRN, New Delhi
- SOCHARA, Bangaluru
- PRAYAS, Chittorgarh
- Arawali, Jaipur
- Doosra Dashak, Jaipur
- Mac Arthur Foundation
- ICCHN, Pune
- Sir Dorabji Tata Trust

Community Health Fellowship Programme

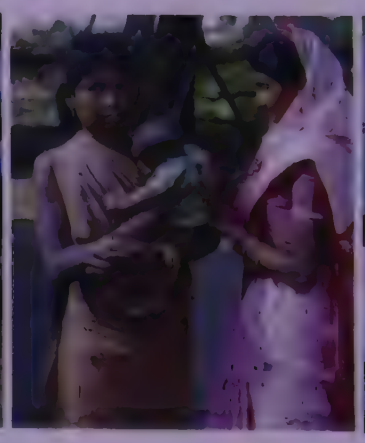
Fourteen community health fellows are deployed in Rajasthan and also nine each in Jharkhand, Bihar and Orissa. There is good coordination with mission directors in all states. Effective mentoring process has been put in place. Programme is also expected to start with 15 fellows in Madhya Pradesh.

These fellows are young dynamic post graduates in social work or community development related areas, who aspire for a life time career in this area and have a high social commitment. They are paid for by NGO funding agencies, and they are trained by a network of NGOs, PHRN in the three eastern states, SEARCH, Prayas & Araveli in Rajasthan & CHC in Madhya Pradesh. The fellows have fixed terms after which the programme will try to find them placements within the health system or with civil society working in the health sector. These fellows are trained and supported by mentors to help the districts improve the functioning of any health programme involving decentralization and community participation - ASHA, VHSCs, RKS, district health plans, disease control programmes etc. They are also trained in research methodology and documentation skills as also inspired by well known role models of public health action. This programme is showing much promise and could prove a way of states finding a dedicated young leadership to provide dynamism to the community process elements of the NRHM at the district level, as well as involve national AMG organizations to play a more active facilitator role.

The NHSRC role is in conceptualisation of the scheme and the provision of technical support, linkages with states and utilisation of their research outputs. NGO support agencies like ICICI Centre for Child Health and Nutrition (ICCHN), Sir Dorabji Tata Trust & Mac Arthur Foundation have come forward to support this fellowship programme.

Community Monitoring Programme

NHSRC participated in evaluation. Programme has been effective to improve delivery of services in the areas where it was implemented. The challenge is now to get a buy-in of states to make this programme a part of their state plans. This programme is managed by Advisory Group on Community Action, and NHSRC helps where required of it.


STATE HEALTH SYSTEMS RESOURCE CENTRES

In a country as large as India, the institutional capacity required for provision of technical assistance and for guiding the massive capacity building needed, must become available within every state. The NHSRC alone cannot, and even should not, perform this role. Nor can any other national body or even group of institutions at the national level, cater to the need of every state and district.

This is the reason that the NRHM envisaged that every state would develop institutional capacities to provide the technical support and capacity building needed for health systems development. This could take the form of State Health Systems Resource Centres, or it could take any other institutional form, provided the purposes for which they are set up are achieved. Consultant's teams hired for an immediate purpose may continue to be necessary but they are not to be seen as a substitute for a state level institution which would be more sustainable and which would provide the institutional memory that planning and capacity building requires.

Over the past two years states have tried various arrangements. These include outsourcing all technical assistance needs, placing the team within the SIHFW, building a team with development partner support or registering a new society. These have met with various degrees of success. States have also taken time to assess their need for such an institution and to position a new institution such that it does not duplicate or substitute any existing institutional capacity.

The NHSRC acts as a vehicle for sharing such experiences. The NHSRC also assists states to establish SHSRCs where it is requested to do so. It assists in induction and mentoring of the new SHSRC teams. Further it plans every one of its interventions in coordination with the SHSRCs so that there is mutual learning and capacity building within these institutions.

One central challange that SHSRCs would face is the limited recognition of the need for technical inputs for building health systems. Health leaderships recognize the 'technical' in decisions regarding choice of drugs, vaccines etc, but not as much in areas like organization development, human resource planning, management information systems, community participation etc. If SHSRC's are not to be limited to serving as extra hands to hard pressed administrators, but emerge as catalysts, innovators and creative designers of improved health systems, they would have to be assisted to win that place for themselves. SHSRCs would need strong linkages with NHSRC and many other public health education and research institutions and agencies to be able to fulfill their mandate.

Evolving and disseminating guidelines

In October 2008, at the Puducherry national workshop on HR and public health management, there was a discussion on the need and agenda of SHSRCs – and the need to have some institutional mechanisms for technical assistance and managing change in the process of strengthening and architectural correction of state health systems. Such an institution should not duplicate but it should synergise with other state level structures, especially the directorate, the SPMU and the SIHFW. However in the period since then the progress made in building state capacities in many of these areas has been limited. On April 9th 2009, a one day national workshop and consultation of existing SHSRC directors and of mission directors in other states was called to understand the progress made in setting up SHSRCs and the problems faced. The workshop was chaired by the Mission Director and attended by the JS, NRHM. Based on these discussions, a draft new guidelines was circulated for the comments of the workshop participants. These guidelines were issued in the last week of April and they have considerably speeded up progress on this front. These guidelines were sent to all states and shared with development partners during the JRM process.

NHSRC support

NHSRC has been assisting states to define the positioning design of the SHSRC, its institutional terms of reference and the consultant composition and terms of reference for individual consultants. As part of this process, the first step is visiting the states, and mapping of institutions active in different forms of technical assistance or capacity building at the state level, and defining the consultants they have and the functions they are playing. Then through discussion help the state to define what is needed and the best options for institutional mechanisms. State by state account of progress on this agenda is given below. Currently SHSRC is planned only for states with over one crore population. For smaller states additional consultants can be taken directly into SPMUs or directorates. For the small states of the north-east, the NE-RRC hires the consultants and places two or three at the disposal of the state and the rest of the TA activity is being managed from the regional office.

Focus States

Uttrakhand

State Capacity Assessment Done. Posts needed and TORs evolved through a dialogue. The SHSRC is proposed to be setup with some posts funded by USAID and the rest by NRHM. Mission Director (NRHM) would act as ED SHSRC. Would have separate bank account and identity but legally part of the SPMU. Recruitment is being done by NHSRC for 10 consultant positions in the areas of Maternal Health, Public Health Planning, Quality Assurance, HMIS, Nursing and Human Resource Development, Healthcare Financing, Community Process, Documentation officer, Data manager and IEC.

Bihar

Assessment of state institutional capacities completed. TORs and Modalities of setting up of SHSRC finalized. Formal approvals by state awaited. The Centre would also have part support from DFID.

Orissa

Assessment of state institutional capacities done. DFID-TAST working as Resource Centre at present. State is considering organizing some of the consultants in SPMU as a team who would have an SHSRC identity – separating those involved in administrative implementation with those providing technical assistance. SPMU has 15 consultants now. The SHSRC could be a separate body or it could be with SIHFW or just a part of SPMU. No decision on this has been taken as yet.

Madhya Pradesh

DFID-TAST functioning as Resource Centre at present. State desires to setup a policy wing, a technical support wing with TAST as SHSRC and operational wing which is SPMU.

Rajasthan

SHSRC created and initially placed under SIHFW. It showed a staff of six consultants on deputation namely consultant (Public Health Planning), Project officer (ARC), a project officer, SHSRC and 3 Research Officers. Three rounds of recruitments failed to recruit suitable consultants. Recent decision to move the SHSRC and ARC to the directorate and PMU has potential to vitalize this institution and make it more output oriented.

Jharkhand

SHSRC to be setup in Public Health Institute, Ranchi. A registered society is proposed. NHSRC will assist in the recruitment.

Uttar Pradesh

Former SIFSPSA now playing many of the functions of a SHSRC. This is USAID funded.

Chhattisgarh

Well functioning SHSRC. Established in 2002, under a new director since 2007. Grown in last two years in range on functions and in size with almost 40 employees now. Has found new SHSRC guidelines valuable to strengthen itself. SHRC guides the entire Mitanin programme and VHSC programmes, and programmes to reach IPHS. Also taking on quality assurance programmes. Handles TA needs in a wide variety of areas. Recently being asked to focus on HR programmes.

Other large states

West Bengal

Strategic Planning & Sector Reform Cell (SPSRC) has been developed and is functioning as SHSRC equivalent. It has similar staff and functions as that of NHSRC. SPSRC has 8 consultants out of which 4 are state officers and 4 are external consultants. There is also a smaller SHRC which functions as a knowledge repository. A DFID-TAST group also provides technical assistance support. There is a SIHFW and an RRC also. The SPPRC has defined its work areas very well, but has to detail a plan of action and the deliverables.

Haryana

At present, one consultant in SIHFW functioning as SHSRC. Detailed proposal is pending at the state government level. The state has expressed interest in getting recruitment done by NHSRC- but TORs yet to be finalized.

Punjab

One round of tendering to select a TA agency to play this role, did not fructify. Now planning to select a team of consultants directly. TORs for consultants sent to the state by NHSRC for 10 proposed consultant posts namely PHP, HMIS, M&E, Quality Assurance, Financing, AYUSH, Community Processes, Human Resource Development led by ED. Also require a Maternal Health specialist and IEC/BCC expert. Formal request for recruitment will be received.

Kerala

Assessment of state institutional capacities done. With NHSRC assistance state has drawn up a detailed terms of reference for the institution and its consultants. Propose to locate it within SIHFW. First batch of consultants recruited. Advertisement for other consultants being issued by the state.

Maharashtra

SHSRC is in place with ED (retired DGHS of the state), one consultant from GTZ and three newly recruited consultants. Three posts which did not get filled up are being re-advertised. It has adequate space in its newly created office at Pune.

Tamil Nadu

Does not want a separate institution now, but has requested NHSRC to setup an extension centre at RRC to function as SHSRC for the state, as it needs technical assistance in some areas.

Karnataka

Assessment of needs done and the framework and TORs for the SHSRC were prepared by NHSRC. Recruitment for SHSRC for 5 posts completed namely Consultant (Public Health Planning), Consultant (Health Care Financing), Consultant (Human Resource Development), Consultant (Quality Assurance) and Consultant (M&E). The post of Team leader has been re-advertised.

Delhi

No detailed assessment done. State has expressed its desire to get recruitment done by NHSRC. Detailed proposal will be sent.

RCHA
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COMMUNITY HEALTH LIBRARY AND INFORMATION CENTRE

Himachal Pradesh

Proposes to strengthen SIHFW and Training Centre (TC). Not planning for a separate SHSRC.

J & K

State plans to setup a core-group of experts to provide technical support in the area of Planning, Maternal Health, Child Health and Immunization and Disease Control and Inter Sectoral component under project management component of RCH-II. The officers are proposed to be on deputation to the State Health Society from the Department of Health.

Gujarat

SHSRC outsourced to EPOS in Feb 2009. EPOS pays the salaries required and is reimbursed. The consultants report directly to the team leader – EPOS as such remains largely a holding company. SHSRC has 5 member team supported by six support staff. Team consists of a Team Leader, HR, BCC, Financing and Public Health Consultant.

Andhra Pradesh

State has decided to set up an SHSRC in addition to revitalizing its IIHFW. It has expressed its desire to get recruitment done by NHSRC. TORs and guidelines for setting up of SHSRC have been shared with the state. An evaluation & organisational development study of the IIHFW has been completed by NHSRC.

Special Focus State : Bihar

As a special situation, NHSRC has deployed a full time team of four consultants in Bihar with the support of one advisor and one senior consultant. This was requested by the state, given the time it takes for institutional reform and setting up SHSRC in Bihar- and in the meanwhile to get more technical support going.

District Planning & District Health Management :

The central contribution in Bihar has been in building up district level capacity in a team of 5 officers, to understand the NRHM & undertake district health planning. Three batches of officers have been trained with submission of 24 final DHAPs. Another 14 DHAPs remain to be finalized. PHRN team's support has played essential role in the success of this initiative..

HMIS

A data collection system, with good data status & data quality has been put in place . State also has its own web based HMIS for state specific health programmes. Designing & implementation an Integrated Information Support System involving six data bases - Human Resources, Financial Reporting, Infrastructure Management, Drug Supply, Patient Based Data Base, and Licensing System.

Drug procurement and supply

Procurement audit done. Bihar is preparing to implement a TNMSC type equipment, drugs and supplies procurement and distribution system.

Community Processes

Progress slow. VHSCs recently notified. ASHA still in 2nd round training. Consultations to strengthen the ASHA support systems as well as accelerate training, being organised Needs institutional change. In community monitoring, NHSRC has supported PFI for the development of a tool for community monitoring based on 30 cluster sampling.

Responsive Technical Assistance

NHSRC team has been requested by the state for assistance in evolving and issuing orders for a number of initiatives. These include Maternal health audits, display of service guarantees in public health facilities, and for free radiology and pathology services to reach the poor etc.

Human Resource

Innovative workforce performance appraisal approach developed and a government order issued. This order puts in place a system for recognition of good performance. Draft govt. order prepared for reservation of 50% PG seats for government doctors in the clinical disciplines. In the non-clinical subjects all seats proposed to be reserved for government sector candidates. Bonus marks in the entrance examination for working in remote areas. A study on situation of nursing has led to a state action plan on nursing. This is being followed up & supported by the team.

Improving Quality in Public Hospitals
NHSRC - ISO Certification Process

Improved Aesthetics - Korba Hospital

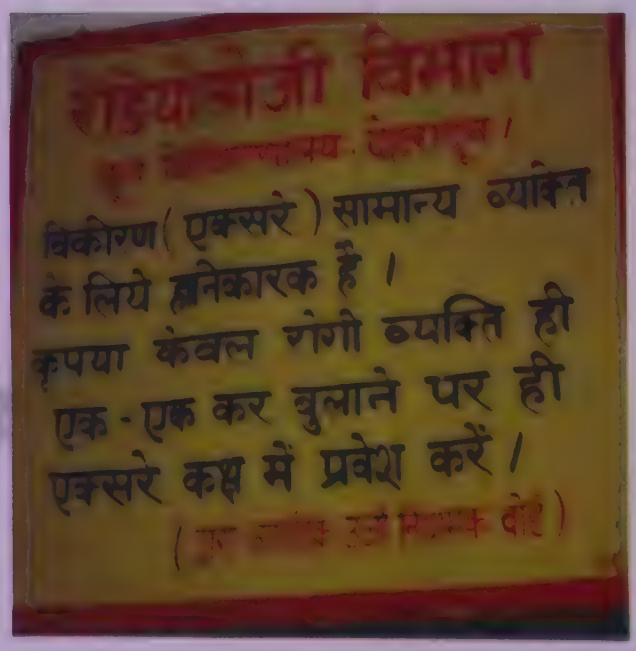
Before

After

Improved Signages

Before

After

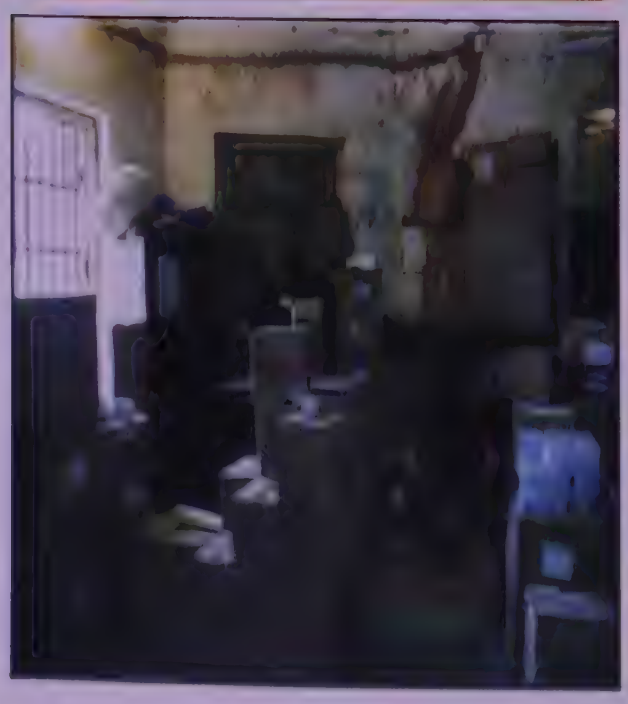


OTHER AREAS OF NHSRC CONTRIBUTION

Strengthening Governance in the Health Sector
New State Health Society office in Bihar

Improved Supply Side Management and Promotion of Rational Drug Use

Before



After

Induction of technical skills

This is not a central task of NHSRC but seeing the urgency and huge dimensions of this task, NHSRC was requested to step in. NHSRC also uses this assignment to understand what attracts skilled human resources to such tasks. NHSRC also organizes induction training where needed. The quality of program processes can be greatly influenced in the long-run by strengthening the quality of recruitments under NRHM. However, NHSRC sees this role as transient.

Uttar Pradesh

In First Round - Recruitments were done for total 288 vacancies of 4 positions of District Program Manager, District Accounts Manager, District Community Mobilizer & District Data and Accounts Assistant. Total of 266 vacancies were filled. 7 positions of state level program assistants were also filled.

In Second round – recruitment done for 823 block level vacancies of Data cum Accounts Assistant. Final result has been sent to UP SHS.

Chhattisgarh

For NRHM state and district level positions –the state had requested us to recruit for 6 District Program Manager positions, and 6 state positions, including one post each of State Program Manager, State Finance Manager and 4 other consultant positions in areas of MCH, HMIS, M&E, and Procurement. Final selections were made on all but 2 consultant positions at state level (Procurement and MCH). The SHRC has now taken over recruitment of technical skills.

Technical Assistance Agencies

- Srijan Infratech, New Delhi
- Hero Mindmine, Gurgaon

Community Health Fellowship Program

Against 46 positions of Fellows for 4 states of Bihar, Jharkhand, Orissa and Rajasthan, 42 were recruited. Here the NHSRC only assisted with the short-listing process and attended the interviews.

Integrated Disease Surveillance Program (IDSP)

For 766 consultant positions across the country, a total of 601 have been recruited. The number of posts were State and District Epidemiologists 35 and 646 respectively, State Microbiologists and Microbiologists for priority District level Laboratories, 35 and 50 respectively, and State Entomologists 35. Recruitment process for remaining vacant positions is underway.

National Vector Borne Disease Control Program (NVBDCP)

- For 12 vacancies of Malaria Consultants, 12 were recruited.
- For 140 vacancies comprising of 14 National (2 Procurement , 1 PH, 1 Training, 3 Financial Management/ Accounts and Budget , 1 NGO/PPP, 1 BCC, 1 M&E, 2 IT, 1 Environment Safety, 1 RO) 25 State (5 M&E, 5 Procurement, 5 Financial Management, 5 NGO/PPP, 5 Training), 5 Regional (Vector Control)and 96 District (Malaria/VBD), 133 vacancies filled.

- Remaining 7 unfilled vacancies of State (2 M&E, 5 Training) and 30 new vacancies comprising of 6 National (2 PH, 1VC, 1 Procurement, 1 Training, 1 M&E), 24 State (3 Kala Azar, 8 VC, 3 Social Development, 3 Training, 1 Procurement & Supply, 1 Financial Management, 5 Entomologists) are in process.

SHSRC Karnataka

For total 6 Senior positions in the areas of PHP, Health Care Financing, M&E, Quality Improvement, HRD and a Team Leader, 5 were selected. The position of team leader is re-advertised and process is nearing completion.

SHSRC Uttarakhand

Recruitment for total 10 positions of Consultants: Public Health, Mental Health and Non-communicable disease, Financing, Monitoring & Evaluation, Quality Improvement, Nursing & Human Resource Development, Community Process, IEC & HMIS and Documentation is in process.

New Areas of Intervention

Governance Indicators

There has been considerable discussion on the development of governance indicators. A conceptual framework has been discussed and preliminary discussion on indicators has taken place. Need to explore with the Mission, the usefulness of developing such a tool and take it forward.

Health Communication

The focus of NHSRCs contribution is to develop district level capacities to identify and design health communication programmes as part of the district plan. Also to develop the skills of formative and outcome evaluation as pertains to BCC work. This work would develop in response to requests from the states.

Assets and Inputs Management Division

There is a major need to address issues of health infrastructure development and of procurement and logistics of equipment and supplies. Many states have requested help in these areas. A large part of the NRHM funds that are spent behind schedule by states are locked up in these areas. MOHFW has also wanted NHSRC to initiate infrastructure audit. Already in the NE, the RRC has set in motion infrastructure audits in all the states. For the other states an RFP for infrastructure audit has been issued to three public sector undertakings working in this area: HSCC, RITES and NBCC. We have limited it PSUs for we need flexibility in developing the proposal further before we go in for open tendering.

Five procurement audits have been done and need to be followed up. Managing all of this needs a dedicated team.

A new division for assets and inputs management to take forward the programmes already initiated and further develop this area of work, has been proposed.

Technology Assessment and IPR issues

A scoping study is ongoing to define this work area better. The main issue is to build up guidelines and protocols for the choice of technology and to make critical decisions related to IPR in so far as they affect health systems research and development. On the request of the MOHFW, NISTADS in partnership with NHSRC conducted a workshop in April 2009 on Indian Government's compliance with WHO's Global Strategy and Plan of Action (GSPOA). Scientists from ICMR, Department of AYUSH, DST, Department of Pharmaceuticals, participated. The purpose of the workshop was to develop recommendations for action by Govt. of India under GSPOA.

Crowded OPD in Vaishali Hospital, Bihar
Increasing utilisation of Public Health Facilities

Nursing students in Bihar - The Future of the Public Health Care

WORK REPORT OF NORTH-EAST REGIONAL RESOURCE CENTRE

A Regional Resource Center was set up in Guwahati to serve the eight north-eastern states on 9th November 2005, under the European Union funded, Sector Investment Programme. In July 2007, this was absorbed as a branch of the NHSRC and came under NRHM funding. The NE-RRC played a major role in setting up NRHM processes and institutions in the eight states of the north east. It continues to monitor the programmes in these states on behalf the center, as well as provides technical assistance and capacity building support.

Work Report of North-East Regional Resource Centre :

Capacity Building Workshop for District Health Management

Activities undertaken during 2008–09

As a sequel to the first phase of capacity building workshops a State level Training of Trainers for all North-eastern states was conducted at State Institute of Health and Family Welfare, Guwahati from 22nd to 27th October 2007. The second round of Capacity Building Workshop at Regional Level was held from 28th April to 3rd May 2008 at Administrative Staff College, Guwahati, Assam. It was organized by Regional Resource Centre with support from National Health Systems Resource Centre, New Delhi, Public Health Resource Network, New Delhi and Ministry of Health and Family Welfare, Govt. of India, New Delhi. A total of 58 participants from the eight North Eastern States attended the Workshop. Around 38% of them have attended both the workshops.

The second round of the Workshop was more focused on assignments particularly on Choice of RCH Strategy, Disease Control Programme (mainly Malaria and Tuberculosis), ASHA and Human Resource and Training. Besides these, topics on Population Stabilization, Adolescent Health, Community Monitoring, Inter-sectoral Convergence, Procurement, and Logistic and Supply Chain Management were also covered.

In order to frame Assignments for the workshop, the Regional Resource Centre, North East, Guwahati had undertaken a field exercise on Cluster Survey, Malaria and Tuberculosis, ASHA and Human Resource and Training.

As a part of the follow up of the second round of the workshop, all the 8 NE states had organized the state level workshop in their respective states, in collaboration with RRC-NE. A total of 416 officials were trained from the 87 NE districts; 40% of them had attended the 1st round of Capacity Building Workshop as well.

Also the following activities were carried by the states:

Assignments on Cluster Survey:

Tripura : All the four districts conducted the cluster survey.

- West Tripura identified Bamutia PHC area for conducting the cluster survey and the topic identified was Maternal Health.
- South Tripura had identified Maharani PHC area and the topic identified was on Immunization.
- Dhalai District had identified Ganga Nagar and Nakaship PHC area and the topic identified was Family Planning.
- North District also conducted Cluster survey in two identified PHC areas, Konica memorial PHC and Pecharthal PHC area and the topic was on Immunization.

Meghalaya : Two Districts conducted the cluster survey.

- Ri Bhoi carried out the survey in Umsning CHC Area on Immunization.
- West Garo Hills carried out the Household level facility survey, namely, "Village Health information Schedule" in entire district using 30 cluster survey method.

Manipur : Cluster Survey was carried out in three districts:

- Ukhrul district carried out the household level facility survey in the entire district using 30 cluster methods.
- Chandel district carried out a study on BCC Needs Assessment.
- Imphal West district carried out 30 clusters on Ante-Natal, Intra-Natal Care, Post Natal Care, Family Planning, Child Care, Immunization under RCH.

Although, the above mentioned cluster survey was carried out but it was observed that further improvement in terms of identification of the topics and preparation of questionnaires are required.

Arunachal Pradesh : One district conducted the Cluster Survey:

- Lower Subansiri district carried out the cluster survey in Yazali PHC area and the topic identified was Maternal Health.

FGDs with ASHA were conducted in Tripura (4 PHC area), Arunachal Pradesh (2 PHC area), Assam (3 PHC area), Manipur (1 PHC area), Meghalaya (2 Blocks).

FGD with PRI regarding RNTCP and Malaria in Tripura (3 Nos.), Arunachal Pradesh (2 Nos.)

FGD with mothers was held in Arunachal Pradesh (2 Nos.), and Assam (3 Nos.)

Preparation of PIPs: Draft State PIP was prepared after due consolidation of VHAPs and DHAPs and submitted by all 8 NE states. Draft SPIPs were appraised at different levels and the final SPIPs were submitted in March 2009.

Procurement Audit & Infrastructural Assessment and Reforms

The process initiated through inviting EOIs in the newspapers on 21st January 2009. Short listing of the firms was done after preliminary scrutiny of the technical wings on 26th February 2009.

Based on the presentations made and clarifications furnished, four agencies have been short listed for finalization & RFPs have been submitted by four agencies.

Currently procurement and infrastructure audit, by these firms, are underway in all the north-eastern states.

Health Management Information System

1. Routine field visits up to health facility level for strengthening HMIS scenario in NE states.
2. Support during Cluster Survey conducted in NE states.
3. Implementation of Data Entry in NRHM Web Portal as well as Capacity Building for implementation of DHIS 2 in North Eastern States, in collaboration with NHSRC. The first round of training was conducted in these states as shown below:

State	Date
Assam	14/09/08 to 16/09/08, 25/11/08 to 28/11/08,
Nagaland	29/11/08 to 30/11/08 and 13/01/09 to 16/01/09 (Only by NHSRC)
Arunachal	01/12/08 to 02/12/08,
Manipur	01/12/08 to 03/12/08 and 09/02/09 to 10/02/09 (Only by NHSRC)
Meghalaya	05/12/08 to 06/12/08, 19/12/088, 19/01/09 to 20/01/09 and 22/01/09 to 23/01/09
Mizoram	06/12/08 to 07/12/08 and 26/02/09 to 27/02/09
Tripura	05/12/08 to 06/12/08 and
Sikkim	08/12/08 to 10/12/08

Community Process

RRC-NE provides active support to the ASHA programme. The programme has been doing well in all these states. The RRC-NE has assigned one full-time consultant for community processes in each of these 8 states & there is one regional coordinator for the same.

State-wise updated status of ASHA selection:

State	**ASHA Status (as on 30/03/09)**		
	ASHAs to be selected	**ASHAs selected**	**% of selection**
Assam	26247	26225	99.91%
A. Pradesh	3862	3364	87.10%
Manipur	3878	3225	83%
Meghalaya	6250	6248	98.83%
Mizoram	943	943	100%
Nagaland	1700	1700	100%
Sikkim	636	636	100%
Tripura	7357	7076	91.61%
Total	50873	49417	97.13%

State-wise updated status of ASHA Training:

State	ASHA Training Status (1st – 4th Module) (as on 30/03/09)				
	Total ASHAs selected	Module wise status of ASHAs trained			
		Mod 1	Mod 2	Mod 3	Mod 4
Assam	26225	26225	26225	26225	26225
A. Pradesh	3364	2598	807	729	729
Manipur	3225	3000	3000	3000	3000
Meghalaya	6248	5794	5688	3973	3030
Mizoram	943	943	943	943	943
Nagaland	1700	1700	1700	1700	1700
Sikkim	636	555	555	555	555
Tripura	7076	6961	6767	6348	6228
Total	**49417**	**47776**	**45685**	**43473**	**42410**

Regional level meeting of ASHA Mentoring Group (AMG):

Regional level meeting of AMG was held at Guwahati on 7th Nov'08. Executive Director, NHSRC, Officials from MoHFW, GoI and all the Mission Directors of NE States and representatives from the civil societies attended the meeting. After, this meeting the AMG formation in NE states picked up as the meeting gave a picture regarding the aims of objectives of the AMG.

Constitution of ASHA Mentoring Group (AMG) has been completed in all the NE states except Meghalaya. In Assam, one meeting held on 24th Jan'09, two meetings held in Manipur, one meeting each held in Sikkim, Arunachal Pradesh and Mizoram.

Regional Training for the ASHA TOT Module V:

Two Regional TOTs have been held on ASHA Module V training. First one was held at Guwahati (21st – 24th Oct'08) for the state of Assam. 35 persons were trained as Master Trainers. The second training was held at Agartala (3rd – 6th Feb'09) for the states of Tripura, Manipur, Mizoram and Sikkim. Resource Persons from CHETNA, Ahmedabad attended the training. NHSRC team members and Officials from MoHFW, GoI also attended the training.

District level Training of Trainers (TOT) on ASHA Module V training:

The district level TOT on ASHA module V has already been held in Tripura, Manipur and Mizoram. 30, 99 and 45 persons have been trained as trainers, who will directly train ASHAs at health facilities. Adequate care has been taken to minimize transmission loss. The training for the district trainers in Sikkim will be held soon. The last regional TOT for

Meghalaya, Arunachal Pradesh & Nagaland was held in May 2009.

Procurement of ASHA Drug Kit: This has been procured by all NE states and has also been distributed among ASHAs. PHC has been considered as the lowest unit for drug replenishment. Still trying to get drug re-fills in place.

Notification of integrated ASHA incentive package done in Tripura, Manipur, Mizoram

Assessment of community monitoring activities in Chirnag district of Assam was done in Dec'08 and the report was submitted to the NHSRC.

Other Activities

1. Mother NGO Evaluation of Assam completed during the period March'2008 to May'2008 and the final report published on July'2008.
2. Coverage Evaluation Survey for Maternal & Child Health of Assam completed. The survey was conducted during May'2008 to July'2008 and the final report published on September, 2008.
3. PPP Evaluation in Arunachal Pradesh started in January 2009. Compilation of Data and preparation of Report are going on.
4. A report on Immunization Week (4 rounds) of Assam for the year 2008-09, has been prepared.

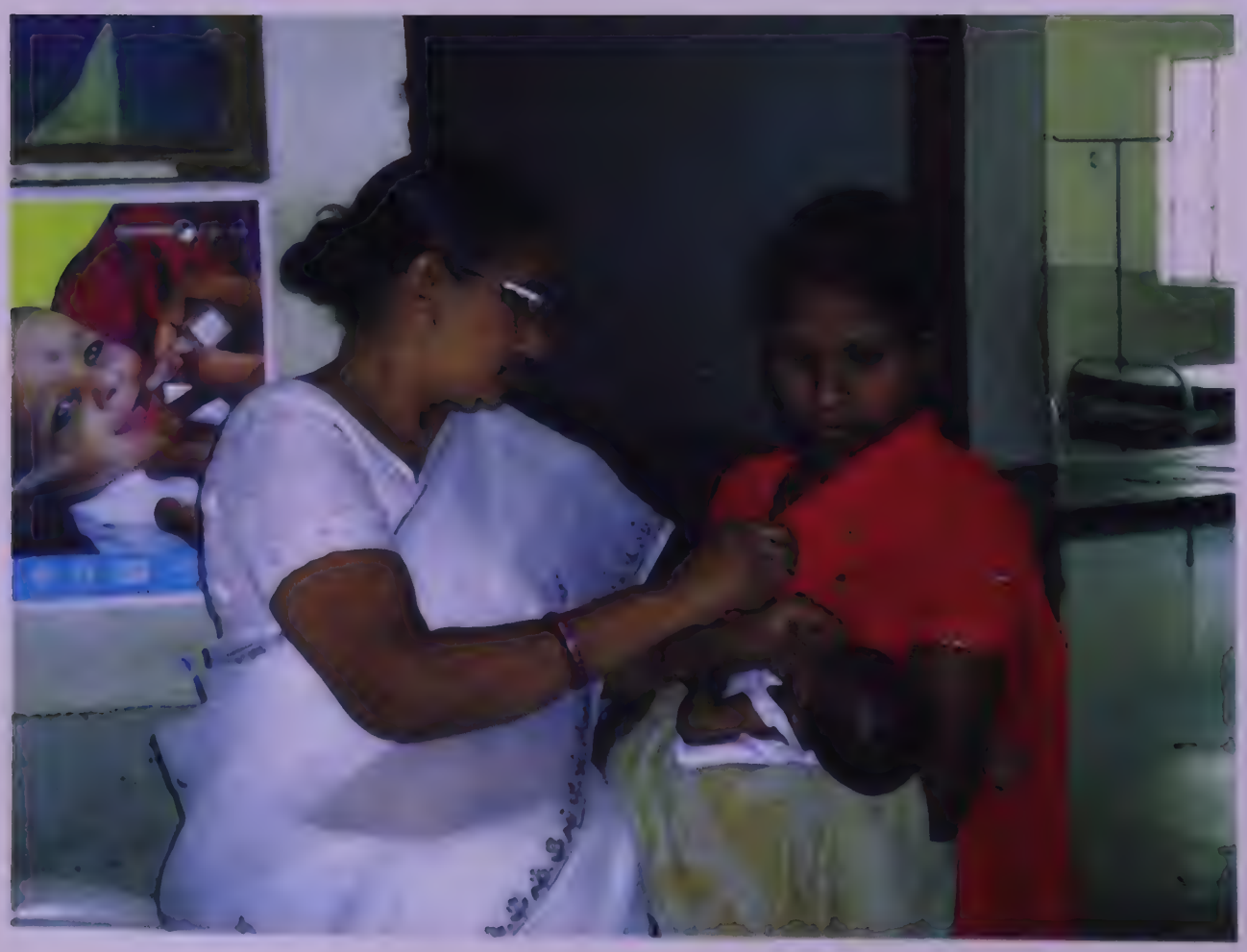
Dr. R. K. Srivastava chairing inaugural session of District Capacity Building Workshop in Guwahati

Joint State Planning Workshop of North Eastern states in Guwahati

Training of Trainers for ASHA programme

CONFERENCES & MEETINGS


प्राथमिक स्वास्थ्य केन्द्र



Workshops & Conferences

Major Workshops and Conferences organized by NHSRC

Note: The events listed below are only those workshops or meetings which contributed to conceptualisation, and development and design of programme strategy. Also note that state level capacity building programmes and workshops, where participants were only from that state are not listed below- even if they were for strategy development for that state.

	Workshop/Conference theme	Venue	Collaborting Partners	Coordinating Division	Date
1.	Rogi Kalyan Samitis and the Quality Improvement of Health Facilities	TISS Mumbai	TISS Mumbai	Public Health Planning	August 10th-11th 2007
2.	National Workshop on 'Strengthening Community Processes under NRHM.' Sensitisation, training and exposure programme for state officials in charge of ASHA programme	Raipur	MOHFW, SHSRC Raipur	Community Processes	October 13th–15th 2007
3.	Planning for Health Human Resource Development in NRHM context	IIT Chennai	MOHFW,INC, Dept. of Humanities, IIT Chennai	Human Resources in Health	2nd -3rd November, 2007
4.	National Consultation Workshop of 'ASHA Mentoring Group (AMG) of NRHM'	NIHFW, New Delhi	MOHFW & AMG members	Community Processes	27 November, 2007
5.	Situational Analysis in Health Management Information Systems (HMIS): Establishing Principles of Design	IIC, New Delhi	M & E Division, MOHFW	HMIS	5 February, 2008
6.	National Consultation Workshop of 'ASHA Mentoring Group of NRHM'	NIHFW, New Delhi	MOHFW & AMG members	Community Processes	16 May, 2008
7	First CRM Report: Workshop for Dissemination to public health institutions.	TISS Mumbai	TISS Mumbai	Public Health Planning	19-20 June, 2008
8	State level Health Budget and Expenditure Tracking Workshop	NHSRC New Delhi	MOHFW & 7 collaborating organisations	Health Care Financing	26 July 2008
9	Presentation on 20 years of HMIS Development in Andhra Pradesh - Ph.D. Dissertation of Dr. Ranjini, I.I.M.,Bangalore	NHSRC, New Delhi	HISP	HMIS	26 August, 2008
10	Workshop: Technical Resource Group (TRG) of AMG.	NIHFW, New Delhi	MOHFW & AMG members	Community Processes	31 July - 1 August, 2008
11	Dissemination of study reports on Human Resources in Health (HRH) in India - Size, Composition & Distribution and Policies related to health system development and HRH.	NHSRC, New Delhi	World Bank and PHFI	Human Resources in Health	11 August, 2008

	Workshop/Conference theme	Venue	Collaborting Partners	Coordinating Division	Date
12	Health Systems Development under NRHM: Meeting the Challenge of Integration	JNU, New Delhi	CSMCH, JNU, New Delhi	Public Health Planning	18th-19th August, 2008
13	National Workshop on 'Human Resources for Health and Management of Health Systems': Meeting of State Health Secretaries & officials	Puducherry	MOHFW, WHO DFID	Human Resources in Health & Public Health Administration	16-18 October, 2008
14	National Consultation for Strategy Development for In-service PG Diploma in Epidemiology for IDSP Consultants	NICD New Delhi	NICD & 9 Coordinating Institutions	Public Health Planning	11 Nov 2008
15	Workshop on 'Use of Information for Building competencies in data analysis, interpretation & use'	NHSRC, New Delhi	HISP India,	HMIS	21-22 November, 2008
16	Strategy and Organisation Development for NHSRC	NHSRC, New Delhi		Quality Improvement	9-10 January, 2009
17	Workshop for development of a curriculum for Family Physicians for NRHM	CMC Vellore	CMC Vellore	Public Health Administration	16 – 17 December,2008
18	National Consultation Workshop of 'ASHA Mentoring Group of NRHM'	NHSRC, New Delhi	MOHFW & AMG members	Community Processes	11 February, 2009
19	Stakeholders consultation for development & accreditation of a curriculum for Family Medicine for NRHM	NHSRC, New Delhi	CMC Vellore	Public Health Administration	4 March, 2009
20	Second State level Health Budget and Expenditure Tracking Workshop	Institute of Health Systems, Hyderabad	MOHFW & 7 collaborating organisations	Health Care Financing	14 March 2009
21	Procurement Audits of 5 states: A Dissemination Workshop	MOHFW, GOI	MOHFW	Health Care Financing	30 March 2009
22	National Review and Planning Workshop on establishing SHSRCs.	NHSRC, New Delhi	MOHFW	Public Health Planning	9 April, 2009
23	Sharing of experiences: Brazil's Experience in Quality Certification for primary health care: presentation by guest speakers from Brazil	NHSRC, New Delhi	World Bank,	Quality Improvement	17 April, 2009
24	Nursing Services in Bihar: Dissemination of Study Report & Action Planning Workshop	SHS Bihar, Patna	Academy of Nursing Studies Hyderabad & SHS Bihar	Human Resources	22 April 2009
25	Workshop on development of governance indicators for Bihar	NHSRC, New Delhi	SHS Bihar, & PHRN	Public Health Administration	24 April, 2009
26	Status of National Plan of Action on Public Health Innovations and Intellectual Property Rights	NHSRC, New Delhi	NISTAD New Delhi (CSIR)	Public Health Planning	24 to 25 April 2009

	Workshop/Conference theme	Venue	Collaborting Partners	Coordinating Division	Date
27	First National Workshop on Faculty Development for In-service PG diploma in Epidemiology for IDSP Consultants	NICD, New Delhi	NICD & 9 Coordinating Institutions	Public Health Planning	25 – 30 May, 2009
28	ASHA National Training Team Development Workshop : Focus on Module 5.	Jawaharlal Nehru University New Delhi	CHETNA	Community Processes	10–15 May, 2009
29	State Workshop on standardization of registers in Bihar	State Health Society, Bihar	SHS Bihar, & PHRN	Public Health Administration	22 June, 2009
30	State workshop on "Supportive Supervision" of Health institutions in Bihar	State Health Society, Bihar	SHS Bihar, & PHRN	Public Health Administration	June 24, 2009
31	Combating malnutrition: Learning from the Thailand experience – shared by Dr. Kraisid Tontisirin	NHSRC, New Delhi	Vistaar, DFID, USAID	Public Health Planning	June 24, 2009
32	'NRHM and Community Based Health Systems in India' - Orientation Workshop for the Kenyan Delegation headed by Hon. Beth Mugo, Minister of Public Health and Sanitation, Kenya	NHSRC, New Delhi	UNICEF and DFID	Public Health Planning	June 29, 2009
33	International Workshop on Integrated E-Health Architectures	Goa	HISP, NORAD	HMIS	29 – 30 July, 2009
34	Orientation Workshop for Research officers of SHRC Rajasthan	NHSRC, New Delhi	SHS Rajasthan	Public Health Planning	3-4 August, 2009
35	National Consultation Workshop of 'ASHA Mentoring Group of NRHM'	NHSRC, New Delhi	MoHFW & AMG members	Community Processes	6- 7 August, 2009
36	HMIS Fellows Workshop	NHSRC, New Delhi	HISP India	HMIS	10–12 August, 2009
37	Information for Action in Indian Public Health Systems: Presentation by Prof. Geoff Walsham; Judge Business School; University of Cambridge, UK.	NHSRC, New Delhi CMC	HISP India CMC Vellore	HMIS division Public Health	11 August,2009 23–24
38	Stakeholders Consultation for finalization of the Family Medicine Curriculum	Vellore		Administration	August, 2009
39	Nursing Services in Orissa: Dissemination of State Report & Action Planning Workshop	Bhubaneswar, Orissa	Academy of Nursing Studies Hyderabad & SHS Orissa	Human Resources in Health	26 August, 2009
40	Workshop on District Planning for Private Sector & Legal Obligations of District Health Systems.	NHSRC, New Delhi	PHRN	Public Health Planning	3-4 Sep 2008
41	Second National Workshop on Faculty Development Program for In-service PG diploma in Epidemiology for IDSP Consultants	NICD, New Delhi	NICD & 9 Coordinating Institutions	Public Health Planning	29 June to 3 July 2009

	Workshop/Conference theme	Venue	Collaborting Partners	Coordinating Division	Date
42	Third National Workshop on Faculty Development Program for In-service PG diploma in Epidemiology for IDSP Consultants	NICD, New Delhi	NICD & 9 Coordinating Institutions	Public Health Planning	20–24 July 2009
42	First National Workshop on Faculty Development Program for In-service training for Microbiologists in IDSP program	NICD, New Delhi.	CMC Vellore, PGI Chandigarh, BJMC Pune, & NICD New Delhi	Public Health Planning	27-28 Aug 2009

Institute of Public Health Bangaluru, Institute of Health Systems Hyderabad, CMDR Dharwad, ISEC Bangaluru, ICCHN Pune, World Bank, GTZ.

9 Collaborating Institutions - Shree Chitra Thirunal Institute of Medical Sciences Thiruvananthapuram, NICD New Delhi, Public Health Foundation of India New Delhi, , Department of Community Medicine, AIIMS New Delhi, School of Public Health, PGI Chandigarh , National Institute of Epidemiology Chennai, All India Institute of Hygiene & Public Health Kolkata,NIHFW New Delhi and NHSRC. Also London School of Hygiene & Tropical Medicine

Major Institutional Meetings

	Institutional Meetings	Venue	Date
1	First Governing Board Meeting	MoHFW, Nirman Bhawan	May 1 , 2007
2	Second Governing Board Meeting	MoHFW, Nirman Bhawan	January 11, 2008
3	Third Governing Board Meeting	MoHFW, Nirman Bhawan	October 13, 2008
4	Fourth Governing Board Meeting	MoHFW, Nirman Bhawan	August 5, 2009
5	Partnership Council Meeting	MoHFW, Nirman Bhawan	September, 2007
6	Partnership Council Meeting	MoHFW, Nirman Bhawan	March 4, 2008
7	Partnership Council Meeting	MoHFW, Nirman Bhawan	April 23, 2008
8	Regional Resource Center-North East :- Finalization of Work Plan	MoHFW, Nirman Bhawan	September 22, 2008

Faculty Development Programme for Epidemiology Course

A delegation from Kenya to study community participation under NRHM

National Training Team Development Workshop, Delhi

Shri Naresh Dayal, Secretary, MOHFW and Dr. Deoki Nandan, Director NIHFW and Dr. T. Sundararaman, Executive Director, NHSRC at the inauguration of NHSRC Office at NIHFW Campus, New Delhi, 14 July 2008

Shri Amarjeet Sinha, Joint Secretary MOHFW and Development Partners at the inauguration of NHSRC office

INSTITUTIONAL PROFILES : NHSRC

(With a Note on SHSRCs)

NHSRC Team on Office Inauguration Day, July 14 2008

Governing Board - NHSRC

(as on 5 August 2009)

- **Shri. Naresh Dayal** - Chairperson
  Secretary
  Ministry of Health and Family Welfare, Government of India
  Nirman Bhawan, New Delhi-110 011.

- **Dr. R. K. Srivastava** - Member
  Director General Health Services
  Ministry of Health & Family Welfare,
  Nirman Bhawan, New Delhi- 110 011.

- **Shri. P. K. Pradhan** - Vice Chairperson
  Additional Secretary
  Ministry of Health and Family Welfare, Government of India
  & Mission Director, National Rural Health Mission
  Nirman Bhawan, New Delhi – 110 011.

- **Shri Naved Masood** - Member
  Additional Secretary, & Financial Advisor
  Ministry of Health and Family Welfare, Government of India
  Nirman Bhawan, New Delhi-110 011.

- **Shri Amarjeet Sinha** - Member
  Joint Secretary (NRHM-I)
  Ministry of Health and Family Welfare, Government of India
  Nirman Bhawan, New Delhi-110 011

- **Shri Amit Mohan Prasad** - Member
  Joint Secretary,
  Ministry of Health and Family Welfare, Government of India
  Nirman Bhavan, New Delhi – 110 011

- **Dr. Deoki Nandan** - Member
  Director-NIHFW,
  NIHFW Campus, Baba Gang Nath Marg,
  Munirka, New Delhi-110 067.

- **Shri Pradeep Shukla** - Member
  Principal Secretary
  Health & Family Welfare Department, Government of Uttar Pradesh
  Vikas Bhawan, Sachivalaya,
  Lucknow – 226 001.

- **Shri B.K. Mohanty** - Member
  Principal Secretary
  Public Health & Family Welfare Department,
  Government of Madhya Pradesh,
  Mantralaya, Bhopal – 462 004.

- **Shri. V. Srinivas** - Member
  Secretary
  Department of Family Welfare, Government of Rajasthan
  & Mission Director, NRHM
  Secretariat, Jaipur-302 005.

- **Shri. Ravi Parmar** - Member
  Executive Director
  State Health Society, Bihar
  Pariwar Kalyan Bhawan, Patna-800 014

- **Dr. Faujdar Ram** - Member
  Director, International Institute of Population Studies
  3, Govandi Station Road, Deonar,
  Mumbai-400 088

- **Dr. Dileep Mavalankar** - Member
  Professor, Indian Institute of Management, Ahmedabad
  Vastrapur, Ahmedabad 380 015

- **Dr. C. S. Pandav** - Member
  Professor & Head, Centre for Community Medicine,
  All India Institute of Medical Sciences,
  New Delhi-110 029

- **Dr. Prema Ramachandran** - Member
  Nutrition Foundation of India.
  C-13, Qutab Institutional Area,
  New Delhi - 110 016

- **Dr. Shalini Bharat** - Member
  Professor and Dean, School of Health Systems Studies
  Tata Institute of Social Sciences
  P.O. Box 8313, Deonar,
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- **Dr A. K. Shiv Kumar** - Member
  Member - NAC & Advisor - UNICEF,
  Unicef House
  73, Lodhi Estate, New Delhi 110003

- **Dr. K. Srinath Reddy** - Member
  President, Public Health Foundation of India (PHFI)
  PHD House, Second floor,
  4/2, Sirifort Institutional Area, August Kranti Marg,
  New Delhi – 110016

- **Dr. Thelma Narayan** - Member
  Public Health Specialist, Community Health Cell
  359, Srinivasa Nilaya, Jakkasandra 1st Main,
  1st Block, Koramangala,
  Bangalore

- **Prof. Gita Sen** - Member
  Professor, Indian Institute of Management, Bangalore
  Bannerghatta Road, Bangalore – 560 076.

- **Dr. T. Sundararaman** - Member Secretary
  Executive Director, NHSRC,
  NIHFW Campus, Baba Gangnath Marg, Munirka,
  New Delhi-110067.

Executive Committee - NHSRC

- **Shri. P. K. Pradhan** - Chairperson
  Additional Secretary
  Ministry of Health and Family Welfare, Government of India
  & Mission Director, National Rural Health Mission
  Nirman Bhawan, New Delhi – 110 011.

- **Shri Naved Masood** - Member
  Additional Secretary, & Financial Advisor
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- **Shri Amarjeet Sinha** - Member
  Joint Secretary (NRHM-I)
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  Nirman Bhawan, New Delhi-110 011

- **Mr Amit Mohan Prasad** - Member
  Joint Secretary (RCH)
  Ministry of Health and Family Welfare, Government of India
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- **Shri B. K. Mohanty** - Member
  Principal Secretary
  Public Health & Family Welfare Department,
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  Member - NAC & Advisor - UNICEF,
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  73, Lodhi Estate, New Delhi 110003

- **Dr. T. Sundararaman** - Member Secretary
  Executive Director, NHSRC,
  NIHFW Campus, Baba Gangnath Marg, Munirka,
  New Delhi-110067.

The NHSRC Mandate, its Institutional Structure and Functional Organisation

The Beginnings

The NHSRC was registered as a society in December 2006. A Governing Board was constituted with 20 members, 10 (later expanded to 11) of whom were ex-officio government officials and 10 non government public health experts. The Chairperson of the Governing Board was the Secretary, Ministry of Health and Family Welfare and the Vice Chairperson was the Additional Secretary of the Ministry, and Mission Director of NRHM. The officials on the board were six senior officials from the central ministry and two secretaries and two mission directors from the high focus states. The non officials were selected from a list of public health experts forwarded by leading academic institutions which are active in public health systems development.

In the first Governing Board meeting, held in May 2007, the mandate of the NHSRC was explained and the Executive Director, was directed to discuss with key stakeholders and suggest an organisational structure and an action plan that could fulfil such a mandate. This was done and approved by the second governing board meeting held in January 2008.

A partnership council consisting of representatives of all the development partners working in India, was constituted to provide a forum to share information and improve coordination on technical support being provided by development partners and by NHSRC. This council has met thrice so far.

The Mandate

Two key documents defined the mandate of the NHSRC.

One such document is the Implementation Framework of the National Rural Health Mission which describes the NHSRC thus:

"A National Health Systems Resource Centre (NHSRC) is being set up to serve as an Apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the States in the Programme. The NHSRC would provide necessary technical assistance to the Mission Directorate." Pg 49. Implementation Framework of NRHM, MOHFW, GOI, July 2006

And again:

"Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/ States /Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general. It is proposed to have one NHSRC at the national level and another Regional Centre for the North Eastern region. State level Resource Centres will be provided for EAG States on a priority to enable innovations and new technical skills to develop in the health system." ibid pg 23

Another document, which conceptualised the NHSRC, is the RCH-II National Programme Implementation Plan. This describes the NHSRC as follows:

"The National Health Systems Resource Centre (NHSRC) has been conceived primarily as an

institution that is responsive to and is available for providing technical assistance to the centre/states for building their capacity for NRHM. The goal of this institution will be to improve health outcomes by facilitating governance reform, technical innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models."

The Management of NHSRC

The Governing Board lays down the policies, frames the rules, and approves the annual plan and budget. In between Governing Board meetings, the Executive Committee which is chaired by the Mission Director NRHM and made up of 10 of the 21 Board members guides the organisation. The executive director reports to this committee and in between meetings of the executive committee to the Mission Director, NRHM.

For the purposes of management, NHSRC has opted for a flat management structure. The 30 consultants at Delhi and another 20 fellows and facilitators spread over the states report to their division heads who may be advisors or senior consultants. These division heads in turn report to the Executive Director. All the administrative staff report to the Principal Administrative Officer who also reports to the Executive Director. To make the process of decision making more consultative and transparent, two management committees are functional. The first is the 8 member secretariat which is part of the decision making process on all administrative issues and the second is 11 member programme committee which discusses, reviews and advises on all programme content and strategy areas. In addition the consultants' fortnightly meeting provides a platform for sharing the conceptual issues and work in progress of each division. This platform acts as a medium of internal capacity building and sharing of the work across divisions.

In September 2008, it was decided to put in place a Quality Management System for NHSRC. It was felt, that since in many ways, the NHSRC is a unique organisation, a fresh approach to organisational development would have advantages. This process began with a strategy and organization development workshop held on 9th January, 2009. The subsequent steps were mapping the key processes and establishing process input and output relationships of each activity in line with ISO 9001: 2008 standard requirements for process quality. This was followed by defining standard operating procedures for key management and programme processes, imparting training on improved process controls, plus instituting periodic management reviews and internal quality audit. In July 2009, the quality management system of NHSRC was certified to ISO 9001: 2008 standards by a third party external agency.

The main outcomes of this organisation,development process were:

a. Development of Annual Work Plan for each division for year 2009-2010 with clear objectives and targets

b. Determination of Key Responsibility Areas of all positions in NHSRC for clarity in delivery for improved outcomes and performace appraisal mechanisms

c. Systems established to receive requests, respond to and review technical assistance and capacity building needs of states.

d. Streamlining of all administrative and financial functions within the organisation.

e. Development of an organisational strategy for institutional growth and improved effectiveness.

The Partnership and "Partnership Network" approach.

Partnerships are the usual basis on which NHSRC is able to conduct its work. Contractual arrangements with financial support may or may not exist in such partnerships. Partners are purposively selected for a stated intention, to work in a long term manner with NHSRC over a series of projects to develop capacities in the partners, so that as institutions they could continue to support the public health effort in a long term sustained manner. This thus becomes part of the mandate of the NHSRC to develop institutional capacities and eventually for the nation to be self reliant in the area of technical assistance.

The MOU is the written expression of these partnerships and the key instrument of defining institutional roles and obligations as agreed to. NHSRC would have developed almost a 100 signed MOUs by 2010 for its different programmes.

Three special "network partnerships" require special mention. One is the partnership with HISP India (Health Information Systems Programme India) which is a not for profit organization funded largely from the University of Oslo's health informatics programme – a form of inter-university collaboration. HISP India allows access to a global network of programme developers who work on developing FOSS- free and open software systems and this gives NHSRC an unique technical advantage in technology development in the HMIS area. The other such partnership is the Public Health Resource Network, a loose network of public health experts interested in strengthening pro-poor public health systems. This partnership has been critical to the entire district level capacity building programme- by getting the material ready, by organizing for the course to get certified by IGNOU, by mobilizing the resource persons for the training camps, by ensuring follow up through the community health fellows and network members etc. The third such partnership is with the nine coordinating organisations of the partners for capacity building in epidemiology of which some of the important players are; Public Health Foundation of India, National Center for Disease Control, SCTMST and Department of Community Medicine of AIIMS. Similar "partnership networks" are also emerging in the area of Human resources for health studies, and in studies in the financing of health care and in formative evaluation of community health programmes.

International partnerships for shared cross-country learning are also emerging rapidly.



NHSRC Team

Name	Designation
Dr. T. Sundararaman	Executive Director
Ms. Sushma Rath	Principal Administrative Officer
Public Health Planning	
Dr. Ritu Priya	Advisor
Dr. K Roy Barman	Senior Consultant
Dr. T. Geetha Rana	Senior Consultant
Dr. V Rajasekhar	Senior Consultant
Dr. Anuradha Jain	Consultant
Dr. Dinesh Jagtap	Consultant
Ms. Jhimly Barua	Consultant
Dr. Shweta Saxena	Consultant (AYUSH)
Health Management Information Systems	
Prof. Sundeep Sahay	Advisor
Mr. Rajeev Jindal	State technical consultant
Dr. Sandhya Ahuja	Senior Consultant
Mr. M K Talukdar	Senior Consultant
HMIS Fellows	
Mr. Abhijit Kumar	Punjab, Haryana, Chandigarh
Ms. Alia Kauser	Rajasthan
Ms. Richa Sexena	Himachal Pradesh
Ms. Itisha Vasisht	Uttrakhand
Mr. Junaid Ahmad Zaroo	Jammu & Kashmir
Ms. Munmun Pandey	Madhya Pradesh
Dr. Namita V Nair	Maharashtra
Dr. Pervwaiz Alam	Orissa
Ms. Rehana	West Bengal
Mr. Sadat Anwar	Uttar Pradesh
Dr. Sanjiv Deofoide	Bihar
Dr. Shakil Jadhav	Gujarat
Dr. Tanupriya Pal	Uttar Pradesh
Dr. Valema Deogam	Karnataka
Quality Improvement	
Dr. J. N. Sahay	Advisor
Ms. Nidhi Jain	Programme Associate
Ms. Ridhima Dutta	Programme Associate
Human Resource for Health	
Dr. D. Thamma Rao	Advisor
Dr. Garima Gupta	Consultant

Public Health Administration	
Dr. P Padmanaban	Advisor
Mr. Prasanth K.S.	Consultant
Community Processes	
Dr. Manoj Kar	Advisor
Mr. Arun Srivastava	Consultant
Dr. Manoj Kumar Singh	Consultant
Mr. H. Nongyai	Consultant
State Facilitators	
Mr. Ajit Kumar Singh	Bihar
Ms. Kanchan Srivastava	Uttar Pradesh
Mr. Randhir Kumar	Jharkhand
Dr. Sajid Ishtiyaque	Uttar Pradesh
Dr. Savita Jain	Madhya Pradesh
Mr. Sushanta Kumar Nayak	Orissa
Ms. Vasudha Gupta	Bihar
Mr. Vishal Kumar Pandit	Rajasthan
Financing of Health Care	
Mr. Gautam Chakraborthy	Senior Consultant
Mr. Arun B Nair	Research Officer
Ms. Riya Dhawan	Research Officer
Legal Framework of Health	
Ms. Shruti Pandey	Senior Consultant
Administrative Team	
Mr. Gambhir Jain	Accounts Officer
Mr. Ashok Pathar	Accounts Assistant
Ms. Uma	I T Manager
Ms. Bhawna	IT Assistant
Ms. Chitrita Bhatacharya	Consultant (Recruitment)
Ms. Ruchi Yadav	Administrative Assistant
Ms. Ashi Karke	Secretarial Assistant
Ms. Krishna Bose	Secretarial Assistant
Ms. Seema	Secretarial Assistant
Support Team	
Ms. Manju Negi	Office Assistant
Mr. Amit Arora	Office Attendant
Mr. Padam	Office Attendant
Mr. .Amit Kumar	Driver cum Office Assistant
Mr. Girish Kumar	Office cum Pantry Attendant

List of NE - RRC Team

	Name	Designation
1.	Dr. A.C. Baishya	Director
2.	Dr. M. Dilip Singh	Advisor, Public Health
3.	Dr. Ashoke Roy	Advisor, Public Health
4.	Mr. K.K. Kalita,	Advisor, Procurement & Logistics
5.	Mrs. Rita Devi Tamang	Coordinator, Capacity Building of the District Health Management
6.	Mr. Biraj Kanti Shome	Consultant, Community Mobilization
7.	Mr. Devajit Bora	Consultant, Community Mobilization
8.	Mr. Wahengbam Imo Singh	Consultant, Community Mobilization (Mizoram)
9.	Mr. Ram Badan Dubey	Consultant, Community Mobilization (Tripura)
10.	Mr. Bhaswat Kumar Das	Consultant, HMIS
11.	Ms. Sagarika Kalita	Consultant, HMIS
12.	Mr. Sukamal Basumatary	Consultant, Public Health Planning (Meghalaya)
13.	Dr. Padi Tala	Consultant, Public Health Planning (Arunachal Pradesh)
14.	Mr. Surajit Sen	Consultant, Public Health Planning (Sikkim)
15.	Dr Joydeep Das,	State Facilitator, Assam
16.	Dr. Pradip Jyoti Sarma	State Facilitator, Arunachal Pradesh
17.	Dr. (Mrs.) Latashori K.	State Facilitator, Manipur
18.	Mr. Nabin Norbert Sharma	State Facilitator, Sikkim
19.	Mr. Pamrichan Ragui	State Facilitator, Mizoram
20.	Mr. Johnny Kadunsin Ruangmei	State Facilitator, Nagaland
21.	Mr. Bikash Das	State Facilitator, Meghalaya
22.	Mr. Arindam Saha	State Facilitator, Tripura
23.	Ms. Madhusmita Dutta	Accounts Manager
24.	Mr. Hitendra Thakuria	IT Manager
25.	Ms. Nazia Begum Laskar	Office Secretary
26.	Mr. Kushal Haloi	Office Assistant

Guidelines for setting up State Health Systems Resource Centre

(Issued by Mission Director - NRHM, MOHFW, GOI, April 2009)

Background:

On 9th April a meeting was held to review progress of the states in setting up State Health Systems Resource Centres (SHSRCs) and organizing to meet their technical assistance needs. These institutions are essential for states to strengthen their public health systems and to drive the sector reforms needed to absorb the finances being made available under NRHM and achieve desired results. To lead in this work a National Health Systems Resource Centre (NHSRC) has been set up at national level. Every state with population over one crore is being provided with funds of Rs. 50 lakhs to one crore per year to set up a State Health Systems Resource Centre. Progress in setting up these SHSRC has been varied. In this meeting, the main reasons for slow progress were identified and a set of recommendations are agreed upon- which is the basis of these guidelines.

Reasons for slow progress:

1. Inadequate clarity on terms of reference & on distinction between consultants' tasks in SPMU, SIHFW & SHSRC.
2. No suitable consultant available/identified and no team leader identified who can guide/mentor junior/fresh recruits to develop skills in different areas.
3. Compensation package for consultants, fixed at Rs. 26000, fails to get adequate quality of consultants, sometimes not even fresh recruits. But if fixed at higher scales we run the risks of the posts being occupied by persons senior in age, influence, and years of experience, but without requisite skills set and attitudes as is required for managing 'charge' & leading in new and emerging areas of health systems development work.
4. Lack of clarity on institutional arrangements – difficulty in creating new registered societies while existing societies being non-functional/unable to take on this task. These societies need ownership by government so as to develop responsiveness to the mission's needs, but yet be functionally autonomous for both reasons of HR requirements and longer term institution building.

Terms of reference: The national workshop on HR & PHM held at Puducherry issued model TORs, for SHSRCs, SIHFWs & SPMUs. These are annexed. These could be adapted for each state.

Recruitment of consultants, team leaders, compensation packages and skill development:

Normally all consultants should be provided a maximum compensation package of Rs 26,000.

However compensation packages in two higher slabs- Rs 26,000 to Rs 40,000 and Rs 40,000 to Rs 65,000 could be permitted if the following conditions are strictly adhered to:

a) Selection is against individual TORs which specify work output.

b) It is made clear that this is a consultant fee, and not a grade of pay or seniority and exact amount could vary depending on what is available and needed to do this job.

c) Selection is done by an open and transparent process through a board constituted by the secretary or mission director of the state and in this, NHSRC shall be represented.

NHSRC could help by undertaking the recruitment, or by assisting the states in finding candidates for SHSRC

Institutional arrangements:

We suggest a registered society with a governing board made of representatives of the government and public health experts and activists. Alternatively it could be outsourced to one agency, which is able to give this institution the space to develop independently, under a broad based steering committee and eventually hand it over to the state health society. If both of these options are not feasible one could start these with appointment letters issued by the state health society, but functionally organized as a team of consultants sharing a common office space and support structure and reporting to a team leader. In such a context, the SHSRC team leader should report to the Mission Director and to the principal secretary of health services. The NHSRC could assist in detailing the institutional arrangement if asked to do so.

In parallel to this effort, the SIHFW should also be strengthened.

Timelines:

All states are requested to finalize their plans on the basis of these guidelines and start the process of recruitment from the mid of May. This timeline is essential to improve the quality of district and state planning and implementation of these plans in the current year itself.

Coordination with NHSRC:

NRHM has prioritized six areas for building up technical capacity in the states. It is essential that States have one or more consultants who can work along with NHSRC in each of these six areas and in the process develop their own capacity. If these consultants are part of the SHSRC then, in the process of reaching the objectives, a viable SHSRC is also built up. These six areas are:

a) Getting the HMIS operational and using information for improved programme management.

b) Developing state specific HR plans and handholding states to implement such plans

c) Better quality of community processes especially ASHA and the VHSC programmes.

d) Better construction and negotiation of PPPs, and budget tracking and analysis.

e) Quality assurance and improvement systems, especially for hospitals.

f) Building capacity for integrated district plans, their appraisal and financing.

Community Health Workers - Mitanins / ASHAs of Chhattisgarh

". . . Recall the face of the poorest and the weakest man [woman] whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him [her]. Will he [she] gain anything by it? Will it restore him [her] to a control over his [her] own life and destiny? In other words, will it lead to swaraj [freedom] for the hungry and spiritually starving millions?"

- Mahatma Gandhi

"Decentralized Planning, Preparation of District Plans, Community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the super-structure of the NRHM would be built. The implementation teams particularly at district and state levels would require development of specific skills. Even at the Central level, the program management units within the MOHFW would need technical and management support from established professionals in the field. The National Health System Resource Centre (NHSRC), which is envisaged as an agency to pool technical assistance... would be ideal for this purpose. Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/ States /Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general."

Pg 23 Section J para 23: National Rural Health Mission –Framework for Implementation..

"The National Health Systems Resource Center (NHSRC) has been conceived primarily as an institution that is responsive to and is available for providing technical assistance to the center/states for building their capacity for NRHM. The goal of this institution will be to improve health outcomes by facilitating governance reform, technical innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models.

The NHSRC would :

- "Create a network of institutions and individuals to improve the capacity, efficiency and outcomes of health systems through meaningful interventions at the national, state, district and sub-district levels..."
- "Be a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems across countries and Indian states..."
- "Above all, improve district and state management capacities in program implementation, fund management and data fidelity..."

Extract from RCH-II National Programme Implementation Plan.

.... The attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

.... Primary health care is the key to attaining this target as part of development in the spirit of social justice.

Declaration of Alma-Ata.
International Conference on Primary Health Care, Alma-Ata,
September 1978

.... If India is to stay committed to achieving the National Health and Population Policies in 2010 and the Millenium Development Goals in 2015, this Commission recommends that public spending be increased from the current level of 1.3% to 3% of GDP in the next few years. The additional resources can form the building blocks for implementing the Commission's recommendations for a strong and viable health care system in India.

Report of The National Commission on
Macroeconomics and Health 2005, page 8

National Health Systems Resource Centre

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